S
362.2
I3mS
1978

1978

Montana State Plan

for

PLEASE RETURN STATE DOCUMENTS
JAN 27 '77

Comprehensive

Mental Health Services

Montana State Library
3 0864 1004 9855 2

THE MONTANA STATE PLAN FOR COMPREHENSIVE MENTAL HEALTH SERVICES is submitted for review by NIMH, State Mental Health Advisory Council and Community Mental Health Regional Boards and Other Interested Parties

---

JULY 15, 1977

Prepared by:

Montana Department of Institutions

Digitized by the Internet Archive
in 2010 with funding from
Montana State Library

http://www.archive.org/details/montanastateplan1978mont

STATE PLAN FOR

COMPREHENSIVE MENTAL HEALTH SERVICES

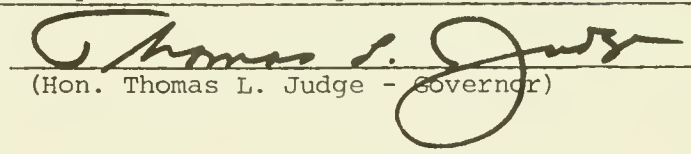
GENERAL INFORMATION

DEPARTMENT OF INSTITUTIONS
(Designated State Mental Health Agency)

Lawrence M. Zanto
(Director)

Hon. Thomas L. Judge
(State Chief Executive Officer)

Public Review Period July 15, 1977 to August 15, 1977

Certification for Approval 
(Hon. Thomas L. Judge - Governor)

Public information concerning
this plan and public comment on
plan contents should be addressed to:

MENTAL HEALTH FIELD SERVICES BUREAU
1539 11th Avenue
Helena, Montana 59601

MONTANA STATE PLAN FOR

COMPREHENSIVE MENTAL HEALTH SERVICES

Under Public Law 94-63
Known as Public Health Services Act
Amendments of 1975

PLAN PERIOD
July 1, 1976 through June 30, 1981

Prepared by:

Montana Department of Institutions

TABLE OF CONTENTS

	Page
I. Introduction	1
Purpose of the Plan	2
Overview of Plan Contents	5
II. Administration of the Montana Mental Health Program	7
Designation of the Single State Agency	8
State Agency Organization	8
Advisory Council	19
Reports	22
Annual Review	25
Personnel Administration	27
State Plan Administration Funds	29
III. Montana Comprehensive Mental Health Program	31
Present Status	32
Goals and Objectives	63
Manpower Requirements	76
Coordination of Planning	82
IV. Appendix	88
A. Survey of Mental Health Needs & Resources	89
B. Description of Catchment Areas	102
C. Standards for CMHC's	130
D. Percent of Population Below Poverty Level	179

		Page
V.	Attachments	180
	1. Designation of the Single State Agency	181
	2. Letter informing Department of Institutions Compliance with Federal Standards for a Merit System of Personnel Administration.	182
	3. Confirmation of compliance with Federal Non-discrimination Policies	183
	4. Letter regarding "Administration of Funds"	184
	5. Memorandum regarding Multi-County Districting	185
	6. Conversion Grant Rankings	187

LIST OF EXHIBITS

Exhibit		Page
1	State of Montana organization of the Executive Branch	11
2	Department of Institutions	12
3	Montana Mental Health Program	13
4	Montana Mental Health Advisory Council	23-24
5	Warm Springs State Hospital Admission Statistics 1975-1976	38
6	Schematic of Warm Springs State Hospital	54
7	Warm Springs State Hospital Patients by Special Unit (September 14, 1976)	56
A1	Regional Prioritization	97
A2	Estimated Scheduled Weekly Hours per 1000 population	98
A3	Social and Health Indicators - Regional Planning	99
A4	Socioeconomic and Demographic Indicators - Regional Ranking	100
A5	Montana Multi-County Districts	106
A6	Indian Reservations	108
A7	Mental Health Regions	109
A8	Area Mental Health Resources Survey (Region I)	112
A9	Community Mental Health Center Professional Staffing Patterns	113
A10	Area Mental Health Resources Survey (Region II)	116
A11	Community Mental Health Center Professional Staffing Patterns Region II)	117
A12	Area Mental Health Resources Survey (Region III)	120
A13	Community Mental Health Center Professional Staffing Patterns (Region III)	121
A14	Area Mental Health Resources Survey (Region IV)	124
A15	Community Mental Health Center Professional Staffing Patterns (Region IV)	125
A16	Area Mental Health Survey (Region V)	128
A17	Community Mental Health Center Professional Staffing Patterns (Region V)	129

I

INTRODUCTION

I. INTRODUCTION

PURPOSE OF THE PLAN

The Montana State Plan for Comprehensive Mental Health Services has two overall purposes.

-To assure the State's commitment to fulfill its obligations of participation in the Public Health Services Act.

-To provide a mechanism for direction and communication and coordination between the Montana Department of Institutions and other state and local organizations involved in delivery of mental health services.

With these broad purposes in mind, the Department of Institutions views the state five-year plan as only one part of a continuing process of planning, review and evaluation and as such, it will be referred to extensively to assess goal achievement. Specifically, the purpose of the plan from both Federal and State perspectives is as follows.

Federal

In order for any state to meet requirements for mental health funds under Section 314(d) of the Public Health Services Act, or for any mental health project to receive funds under parts A, B or C of the Community Mental Health Centers Act, a state must have a federally approved state plan for comprehensive mental health

services. The National Institute of Mental Health requires states to describe overall goals and objectives for delivery of mental health services. At a minimum, the Plan must describe how each of the following objectives will be achieved.

-Implementation of a pre-admission screening system to eliminate inappropriate placement in institutions.

-Development of alternatives to hospitalization.

-Provision of quality care for persons with mental health problems residing in institutions.

-Provision of followup care for residents who have been discharged from mental health facilities.

-Implementation of statewide standards of maintenance and operation of mental health services facilities and programs.

-Implementation of methods to coordinate statewide human services programs to provide an optimum level of efficiency and effectiveness in service planning and delivery.

In addition, the Plan must describe present catchment areas throughout the State for regional delivery of services. Descriptions must include an inventory of existing facilities and services, results of a survey indicating needs for additional services, and established priorities for each regional area. Finally, the Plan must describe the overall organization structure and methods for administration of the State Plan.

State

From the State perspective, this Plan is considered a timely vehicle to bring together views of State and local government organizations and citizen representatives for delivery of effective and efficient mental health services. This is especially necessary in Montana where the large majority of direct service delivery occurs within five geographic regions administered by five regional mental health boards.

In the Plan development process, a fresh look was taken at present status of the Montana mental health program. As a result, it was determined that Montana is short of achieving Federal and State goals. Improvements are required in the provision of uniform and accessible services across the state, and most important in provision of service alternatives to institutionalization. With this background the plan is intended to provide a framework for:

- Public communication of state goals, policy and strategies for improved delivery of mental health services;
- Coordination of services among several state and local agencies; and,
- Evaluation of accomplishments from year to year.

Being a plan, its focus is on desired outcomes or objectives over the next five years. Achievement of objectives will require a commitment to cooperation by those state and local organizations responsible to improve and broaden needed mental health services.

OVERVIEW OF PLAN CONTENTS

The State of Montana Mental Health Services Plan presents to the citizens of Montana a detailed description of mental health services and functions presently provided and those to be provided over the next five years. The Plan describes State and local organizational structure and responsibilities, present goals and objectives for mental health service delivery, and mechanisms to be used for annual plan review and revision. In addition, an appendix is provided to present revised standards for operation of mental health programs and steps taken to assess each mental health region regarding needs and priorities. The overall purpose of the plan is presented in Section I.

Section II of this Plan describes how the mental health program is administered. The primary purpose of this section is to describe organizational relationships between the Department of Institutions and Regional Mental Health Boards including functions and responsibilities. In addition, Section II outlines steps to be taken for program evaluation, reporting and annual review of the Plan. Finally, this section describes State policy for non-discrimination, personnel standards, conflict of interest and use of funds under Section 227 of the Public Health Services Act for administration of the State Plan.

Overall state goals and objectives are discussed in Section III. Summarized in this section are the results of statewide need and resource surveys to assess priorities for additional services throughout the state. Input during the assessment phase was received from

the State Advisory Council, public hearings and community mental health center regional boards. This input, along with State agency assessment of Federal and State agency requirements, formed the base for establishing specific program objectives and implementation procedures. Section III also discusses estimated manpower requirements for State agency programs and steps to be taken to determine manpower requirements for community mental health programs. Finally, this section describes the nature and extent of State agency coordination efforts with other State and local organizations.

Section IV presents detailed descriptions of the five regional mental health areas including an inventory of existing facilities, results of the need survey and description of services currently offered and those not offered. In addition, this section presents Montana program standards for maintenance and operation of mental health facilities.

Section V lists attachments alluded to in the main body of the plan.

II

ADMINISTRATION OF THE MONTANA MENTAL HEALTH PROGRAM

II. ADMINISTRATION OF THE MONTANA MENTAL HEALTH PROGRAM

SINGLE STATE AGENCY

On April 13, 1976, Governor Thomas L. Judge designated the Department of Institutions as the single State Authority for the administration and supervision of the Montana Mental Health Program. (See attachment 1). In this capacity, the Department of Institutions maintains the authority and responsibility for preparation of the State Mental Health Services Plan and monitoring achievement of program objectives. Further, this department is accountable to the Federal Government for correct expenditures of Federal funds received for Mental Health Administration and program operations under Section 314(d) of the Public Health Services Act and for expenditures under Section 227 part c of the Act.

STATE AGENCY ORGANIZATION

Exhibits 1, 2 and 3 display present organization structure for overall Montana State Government, the Department of Institutions, and the mental health program. The Adaptive Services Division Administrator is responsible for administration of the Bureaus of Mental Health Field Services and Addictive Diseases as well as the following institutions: Warm Springs State Hospital (WSSH), Center for the Aged, Boulder River School & Hospital (BRS&H), Eastmont Training Center, Galen State Hospital and Veteran's Home.

Generally, with the exception of institutional services, the direction of the Department is to delegate major responsibility for service delivery to the five regional mental health boards. However, the Department of Institutions is not legally restricted to provide community mental health services only through regional mental health boards. Community mental health services may be provided for directly by state agencies or indirectly through contract or cooperative arrangements with other agencies of government, regional or local, private or public agencies, private professional persons or hospitals, under rules adopted by the department as described in Section 80-2803(1), R.C.M. 1947.

The following is a summary of functions of each organizational unit within the Montana mental health program. These functions are based on current legal and regulatory requirements of the single State agency.

1. The Director of the Department of Institutions established an Adaptive Services Division (ASD) whose function is to administer and supervise the following mental health related organizational units:

   -Mental Health Field Services Bureau

   -Addictive Diseases Bureau (Current planning intends for this to be a separate Division)

   -Warm Springs State Hospital

   -Center for the Aged

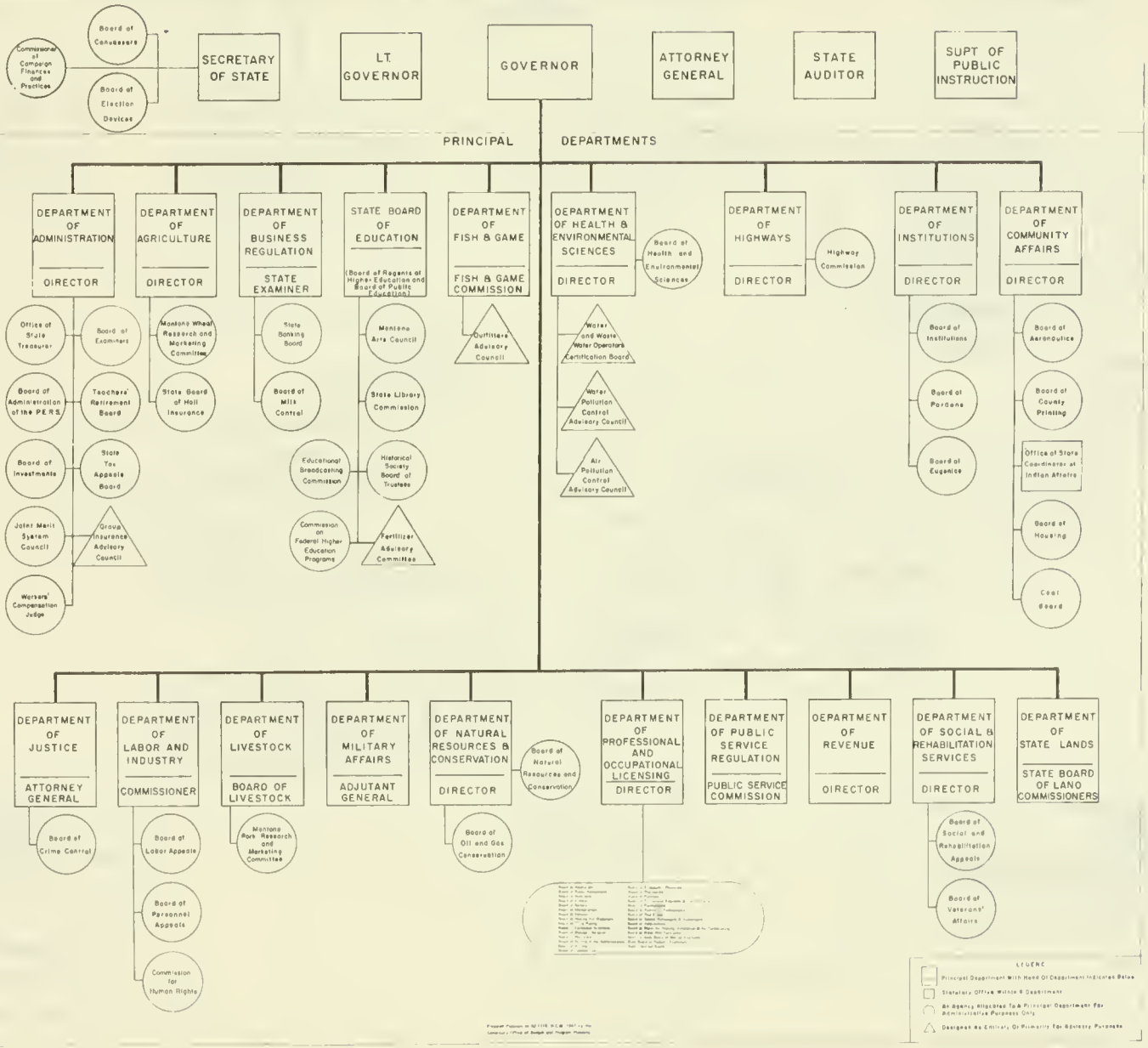
   -Two Psychiatric Nursing Homes (Planning stage)

In addition, the ASD is responsible for monitoring performance of five regional mental health boards. The Division Administrator, Laurance B. Carlson, Ed.D., will provide overall administrative direction and support to the mental health program. In this capacity, he will receive consultation and advice from the State Mental Health Advisory Council for program operations and funding. Dr. Carlson has delegated to the Mental Health Field Services Bureau responsibility for carrying out centralized division functions relating to community mental health centers.

STATE OF MONTANA
ORGANIZATION OF THE EXECUTIVE BRANCH

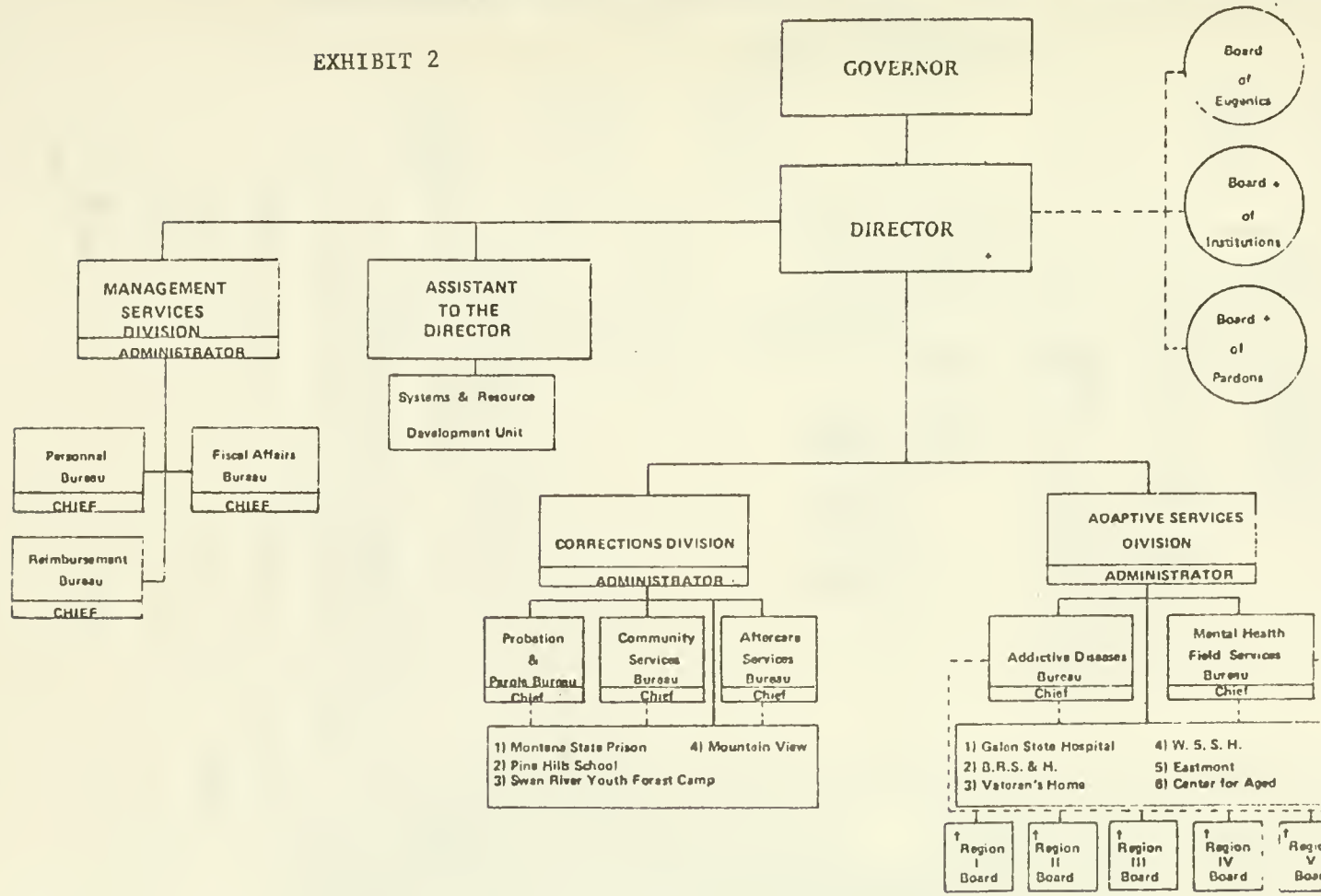
JULY 1, 1975

ELECTED CONSTITUTIONAL OFFICERS



DEPARTMENT OF INSTITUTIONS

EXHIBIT 2



LEGEND:

○ - Quasi - Judicial Boards attached for Administrative purposes.
• - Designates Advisory responsibility.
+ - Designates rule making authority.
† - Regional Mental Health Boards created by State Statutory Authority; These non-profit corporate entities are attached to the Department via performance contract in providing Mental Health and Addictive Disease services.

ORGANIZATION CHART
DEPARTMENT OF INSTITUTIONS

Submitted by: Robert H. Melton
Dr. Robert H. Melton, Director

Approved by: Thomas L. Judge, Governor

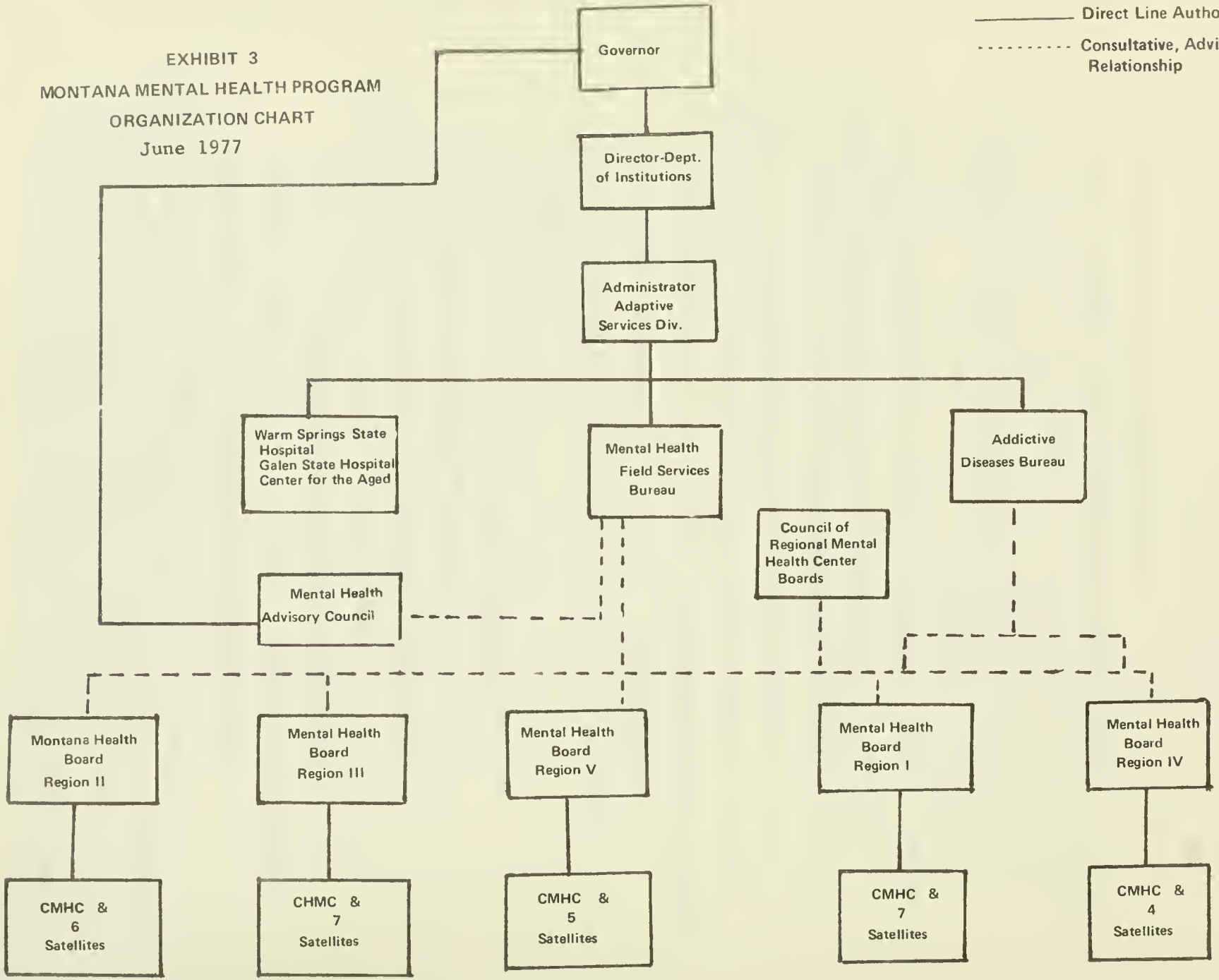
July 1970

EXHIBIT 3

MONTANA MENTAL HEALTH PROGRAM

ORGANIZATION CHART

June 1977


Direct Line Authority
Consultative, Advisory or Monitoring Relationship
Governor
Director-Dept. of Institutions
Administrator Adaptive Services Div.
Warm Springs State Hospital
Galen State Hospital
Center for the Aged
Mental Health Field Services Bureau
Addictive Diseases Bureau
Council of Regional Mental Health Center Boards
Mental Health Advisory Council
Montana Health Board Region II
Mental Health Board Region III
Mental Health Board Region V
Mental Health Board Region I
Mental Health Board Region IV
CMHC & 6 Satellites
CHMC & 7 Satellites
CMHC & 5 Satellites
CMHC & 7 Satellites
CMHC & 4 Satellites

2. The Chief of the Mental Health Field Services Bureau, Mr. Philip Powers, M.S.W., with the assistance of program evaluator, Peter Blouke, Ph.D. and program manager, Edward Bates, M.S.W., will be responsible for supervision of the following State central office functions:

-Facilitate provision of community-based mental health services through provision of technical assistance and training.

-Coordinate an annual review of the mental health program and revise the Mental Health Plan as necessary.

-Develop and implement standards for maintenance and operation of mental health programs and facilities.

-Conduct program evaluations to determine compliance with standards.

-Make recommendations to the Administrator of ASD for approval of funding for community mental health center operations.

-Develop and monitor contracts with community mental health agencies.

Each function of the Mental Health Field Services Bureau and relevant legal or regulatory references are more fully described as follows:

a. Facilitate provision of community-based mental health services through coordination with five regional mental health boards. The State mental health authority is required to insure prevention of mental illness and elimination of inappropriate institutionalization (R.C.M. 1947, Chapter 28) through statewide supervision of federally required services. Technical assistance and training will be provided to each regional mental health program with special emphasis on compliance with standards.

b. State Plan

In compliance with R.C.M. 1947, Chapter 28, the Department of Institutions shall prepare and maintain a comprehensive mental health plan. In compliance with P.L. 94-63 this plan must be based on an assessment of needs and resources and must have an annual review and plan revisions.

c. Standards for Maintenance and Operation

The State mental health authority is required to prescribe and provide enforcement of minimum standards for maintenance and operation of mental health programs and facilities including community mental health centers (P.L. 94-63 and, R.C.M. 1947, Chapter 28). The Mental Health Field Services Bureau will be responsible for development and maintenance of standards.

d. Evaluation

Along with development of standards, the Mental Health Field Services Bureau will implement procedures for (P.L. 94-63 and R.C.M. 1947, Chapter 28):

-determination of compliance with standards including enactment of legally enforceable penalties for non-compliance.

-performance of administrative appeals of enforcement actions.

-performance of periodic review and revision of standards at least every five years.

-publication of proposed modifications to existing standards for review and comment at least 30 days prior to adoption.

-preparation of reports to the United States National Institute of Mental Health about the nature and degree of program deficiencies. Reports will include status of enforcement action of noncompliance with established standards for projects approved under the Community Mental Health Centers Act.

e. Funding

The Mental Health Field Services Bureau shall make recommendations to the ASD Administrator for allocation of State General Funds based on assessment of mental health needs and performance of mental health programs.

3. The Chief of the Addictive Disease Bureau, Mr. Michael Murray, B.A.., will be responsible for overall coordination and planning of statewide drug and alcohol programs. Mr. Murray will work closely with Mr. Powers in consolidating, where feasible, local drug, alcohol and mental health treatment programs. Current planning calls for Bureau of Addictive Diseases to become a division in FY '78.

4. The Superintendent of Warm Springs State Hospital (WSSH), Harry Xanthopoulos, M.D., will be responsible for administration of institutional care to the mentally ill. Supportive services provided at WSSH include:

-individual and group therapy regarding one-to-one or one therapist with several patients.

-occupational therapy regarding specific work training for purpose of resolving psychic malfunctioning.

-recreational therapy regarding planned recreation for purpose of resolving psychic malfunctioning.

-industrial therapy regarding work activities for purpose of resolving psychic malfunctioning.

-educational counseling and training including academic and vocational-technical regarding planned educational activity to rehabilitate patient.

-music therapy: Use of music as a medium to resolve psychic malfunctioning.

-full medical care: medical services as needed.

In addition, WSSH personnel, through contacts with the five Regional Mental Health Centers, coordinate aftercare and follow-up services for discharged patients.

5. As of July, 1975, local community mental health centers (CMHC) were empowered to become private non-profit corporations separate from direct State agency affiliation. Present legal authority of CMHC's is outlined in Sections 80-2801 through 80-2806, R.C.M. 1947 as amended by Montana Senate Bill No. 378 on July 1, 1975. In the same law, the Department of Institutions was empowered to contract with regional mental health corporations for the purpose of the prevention,

diagnosis and treatment of mental illness. In turn these governing boards of centers have created advisory boards to assess needs of citizens and report back to parenthoods. In line with this sanction, the department has chosen to contract with five regional mental health boards for provision of the following services:

-Inpatient: provision of 24-hour short-term care and evaluation typically provided in a medical setting.

-Outpatient: provision of group and individual therapy on a regularly scheduled basis.

-Day Treatment or Partial Hospitalization: provision of less than 24-hour care or partial hospitalization during nights, evenings, days or weekends.

-Emergency: provision of immediate mental health care and evaluation for persons in crisis on a 24 hour a day basis. Service is provided on a face-to-face and crisis telephone basis.

-Children and Elderly: provision of a full range of diagnostic, treatment, liaison and follow-up services with special attention to these two developmental stages who are frequently underserved.

-Alcohol and Drugs: provision of a program for prevention and treatment of drug abusers and alcoholics.

-Transitional or Halfway Houses: provision of residential treatment to individuals released from institutional care who, in the absence of such facilities, would require inpatient services. This service fosters gradual, phased return to community living.

-Aftercare or follow-up: establishment and maintenance of contact with persons discharged from institutions in order to maintain treatment.

-Screening and diagnosis: provision of diagnostic evaluations for courts and other public agencies with persons who are being considered for referral to State mental health facilities. Such screening is also performed for current institutional residents to insure appropriateness of placement.

-Consultation and Education: provision of training and assistance to a wide range of individuals involved with mental health services, including health professionals, schools, courts, state and local law enforcement, members of the clergy, public welfare agencies and other appropriate entities. In addition, provision of mental health education for all citizens of Montana. The governing boards of the mental health centers are mandated by law (R.C.M. 1947, Chapter 28 - 80-2804(2) to be comprised of county representatives designated by the county commissioners for a period of two years. Advisory boards, in addition, are appointed to assist the governing board and staff in assessing community needs, planning, policy making and overall representation of diverse community interests.

-Minorities: provision of comprehensive services to Indians, Chicanos and other minorities members.

GOVERNOR'S ADVISORY COUNCIL

Designation and Role

Governor Thomas L. Judge appointed the Montana Mental Health Advisory Council in July, 1974, to "conduct a thorough study of the current and probable future problems, needs and opportunities the government of the State of Montana will experience in the field of mental health in the next five years, and present its findings, conclusions and recommendations to the Legislature and the Governor, as mandated by legislative resolution" H.J.R. 66.

The Council conducts one two-day meeting every other month. Records are kept of attendance and content of Council meetings. Council activities include:

-Inspections of Warm Springs State Hospital, Galen State Hospital, Boulder River School and Hospital, Eastmont Training Center, Pine Hills School, Mountain View School, Eastern Montana College/Center for Handicapped Children, and several regional Mental Health Centers.

-Public hearings, solicitation of public testimony and public education.

-Assessment of State and other institutions regarding inappropriate placement, and deinstitutionalization.

-Analysis of State statutes and development of suggested revisions.

-Review of present and potential funding mechanisms.

-Discussions of mental health problems of children.

-Consideration of screening and evaluation procedures and services.

-Development of mental health goals and objectives.

-Comparison of Montana problems and programs with those of selected other states.

-Review of selected current prevailing literature.

-Development of liaison with State agencies; Federal, State and local advisory councils and committees; consumer organizations; and professional associations.

-Discussion of prevention, educative techniques and the role of public schools in mental health.

The document containing the findings, conclusions and recommendations of the Council were submitted to the Governor by December, 1976, and to the Legislature by January, 1977. The Council has been funded for two more years to facilitate the implementation of these 68 recommendations.

The Council accepted an invitation from the Department of Institutions to add to Council responsibilities an advisory function for the Division of Adaptive Services, Mental Health Field Services Bureau. Additionally, the Council has agreed to meet with the Mental Health Field Services Bureau staff, quarterly, for the purpose of;

-Assisting in the assessment of needs for mental health services.

-Participating in the annual review and updating of the State Plan.

-Reviewing implementation progress of the State Plan as compared with stated objectives.

The goals and objectives and standards as stated in the Comprehensive Mental Health Services State Plan were submitted to the Council on June 17, 1977. The Council has responded with detailed comments and recommendations.

Composition

The Montana Governor's Mental Health Advisory Council has fifteen (15) members, of which 60% are non-providers of mental health services, and 40% are direct or indirect service providers. As shown on Exhibit 4 on the following page, the Council members originate from each of the five regional catchment areas, and include representatives from the following groups:

-Consumers, including clients and their families.

-Providers of mental health services.

-Non-government organizations and groups.

-State agencies.

Although the final authority rests with the Governor, two additional members are tentatively appointed to the Council to comply with Federal requirements. A Native American and a youth represent their respective groups. The overall membership of the council is being changed at this point to allow for rotation and broad representation, but this will not become final until August 1977.

REPORTS

The Department of Institutions will make such reports in such form and containing such information as the Secretary of the Department of Health, Education and Welfare, may from time to time, reasonably require. The Department will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports.

In addition, the Department of Institutions and regional community mental health centers will retain a file for a period of at least one year beyond participation in the program all documents, accounting records, and control related to any expenditure and will take such steps as are necessary to assure that sponsors retain for a period of at least two years after payment of Federal funds, all financial records and documents related to expenditures for the project.

EXHIBIT 4

MONTANA MENTAL HEALTH ADVISORY COUNCIL

NAME	CLASS	GEOGRAPHIC		OCCUPATION	SPECIAL GROUP REPRESENTATION
		REGION	RESIDENCY		
1. Gary R. Marbut, Chairman	1 & 3	5	Missoula	Rancher/Former Legislator	Developmental Disabilities Advisory Council
2. Gay Ashton	1 & 3	4	Helena	Citizen Advocate/R.N.	Mental Health Association
3. John Dodd, Ed. D.	1 & 4	3	Billings	College Professor/Special Education	Eastern Montana College Mental Health Association Council for Exceptional Children American Association for Mental Deficiency American Personnel & Guidance Association Association for Children with Learning Disabilities Board Regional Services for Developmental Disibilities
4. Artis A. Zody	1 & 3	1	Glendive	Farmer/Former Legislator	Association Retarded Citizens Glendive Mental Health Advisory Board State and Local Association for Retarded Citizens Chairman of Montana D.D. Advisory Council
5. Robert S. Keller	1 & 4	5	Kalispell	Judge	Montana Bar Association

1- Representatives of consumers, including clients and their families
2- Provider
3- Representatives of non-government organizations of groups
4- Representatives of State agencies

EXHIBIT 4 (continued)

MONTANA MENTAL HEALTH ADVISORY COUNCIL

NAME	CLASS	GEOGRAPHIC		OCCUPATION	SPECIAL GROUP REPRESENTATION
		REGION	RESIDENCY		
6. Jane K. Edwards	2 & 4	4	Warm Springs	Nurse	Warm Springs State Hospital
7. Evelyn B. Nikolaisen	2 & 3	4	Helena	Insurance Adjustor	Blue Shield/Mental Health Assoc.
8. Helen M. Huennekens	2 & 3	3	Billings	Mental Health Worker	South Central Mental Health Center
9. Donald L. Harr, M.D.	2 & 3	3	Billings	Private Practising Psychiatrist	A.P.A. - I.P.A. Montana Chapter - M.M.A.
10. Victor J. Beneventi	2 & 3	4	Helena	Counsellor	Carroll College
11. Patricia Gesek	1 & 3	5	Whitefish	Consumer	Western Mental Health Center Advisory Board
12. Jack Carver	2 & 4	4	Helena	Administrator	Social Rehabilitation Service Dept.
13. Jim Johnson	1 & 3	4	Butte	Lawyer	Legal Services Assoc./M.H. Assoc.
14. William Warfield	1 & 3	4	Livingston	Rancher/Former Legislator	Southwest M.H. Center Advisory Board
15. Michael T. Greely	1 & 3 & 4	2	Great Falls	Attorney General	Northcentral Mental Health Center Advisory Board

1- Representatives of consumers, including clients and their families
2- Provider
3- Representatives of non-government organizations of groups
4- Representatives of State agencies

ANNUAL REVIEW

The Department of Institutions views the review and planning process as continuing series of activities resulting in regular plan assessment and revision. On at least a quarterly basis, the Mental Health Field Services Bureau will review progress in achieving plan objectives and prepare a progress report to be distributed to Department management, the State Mental Health Advisory Council, WSSH, regional office of N.I.M.H. and Regional Mental Health Center Boards. SMHA Council will participate in this review. As part of the report, revised objectives or due dates for completion may be necessary depending on identified constraints to achieving expected results. As noted in Section III of this plan, objectives are a combination of expected program changes such as shifts of populations from institutional to community based programs, and administrative changes resulting in increased state agency capacity to monitor program operations. However, achievement of both types of objectives will be monitored to report statewide accomplishments. On at least an annual basis, a summary of these reports along with the following year's revised program objectives will be made public by distribution to the mental health Advisory Council and Regional Mental Health Boards. Further, notification will be placed in all major state newspapers notifying the public of the location of the mental health plan. Results of public comment and annual plan revisions will be submitted to NIMH on an annual basis.

Program Compliance

The Department of Institutions has established an organizational plan within the Mental Health Field Services Bureau to conduct annual site visits to evaluate mental health program compliance with State and Federal standards.

Results of evaluations identify areas for the technical assistance and eventually become the basis for program accreditation. The evaluation process does focus on at least four functional areas as outlined below:

-organization - includes the role of the Board of Directors and Community Advisory Committees, coordination with other human service agencies, procedures used for self-evaluation and use of policy and procedure manuals for staff direction.

-personnel - includes policies and procedures, staff performance evaluation and training programs.

-fiscal - includes budgeting, billing process, and overall control of revenues and expenditures.

-client treatment - includes case record documentation, systems for pre-admission screening and followup on discharged clients, suitability of facilities, hours of operation, and verification of statistical reports described above.

This evaluation process includes submission of a written report of findings to Regional Boards and program management, which outlines strengths, weaknesses and recommendations for corrective action. A formalized response outlining proposed action steps to correct deficiencies and milestones for completion are required from program management.

Personnel Standards

Methods of personnel administration have been established and will be maintained in the State agency in conformity with the Standards for a Merit System of Personnel Administration, 45 CFR, Part 70, and any standards prescribed by the U.S. Civil Service Commission pursuant to the Intergovernmental Personnel Act of 1970. Citations of applicable State laws, rules, regulations and policies which provide assurance of conformity to Federal Merit System Standards and to any standards issued by the U.S. Civil Service Commission are attached for review and determination of adequacy (Attachments 2 and 3). Amendments to this list of citations will be submitted as necessary.

Nondiscrimination

The State agency, State Advisory Council, and Community Mental Health Centers comply with non-discrimination policies for services and employment as stated in Title VI of the Civil Rights Act of 1964 (42 USC 2000D; 78 Stat. 252), the 1972 Montana Constitution, and Title 69 of the Revised Codes of Montana, 1947. (See Attachment 4)

Affirmative Action Plan

The State agency has developed an affirmative action plan to assure equal opportunity in all aspects of personnel administration as specified in 45 CFR 70.4. The plan provides for specific action steps and timetables to ensure equal opportunity. The plan is available for review upon request and is at present being reviewed for final approval by H.E.W. regional office.

Conflict of Interest

In compliance with Montana Law, 59-501 R.C.M. 1947, no full-time officer or employee of the State agency, or any firm, organization, corporation, or partnership which such officer or employee owns, controls or directs shall receive funds from any applicant directly or indirectly for payment for services provided in connection with the planning, design, construction, equipping or operation of any projects funded under the Community Mental Health Centers Act. (See Attachment 4).

STATE PLAN ADMINISTRATION FUNDS

The single state agency for administration and supervision of Mental Health programs including construction of community mental health facilities is the Department of Institutions (see Attachment 1). Methods for administration of federal funds under section 314(d) of the Public Health Services Act (the Act) and section 227 part C for facilities assistance are as follows.

Section 314(d)

Presently the Department of Institutions is allocated 15% of federal funds received under Section 314(d) of the Act. The remaining 85% is administered by the Montana Department of Health and Environmental Sciences for statewide health services. The mental health portion for FY'77 is $82,400. These funds have been distributed as follows:

Central Mental Health Administration - $24,720 (30%)

Regional Mental Health Boards - $57,680 (70%)

Methods used for allocation and administration of funds to regions are:

-Regional Mental Health Boards are notified about availability and amounts of 314(d) funds.

-each Regional Board submits a proposal for use of funds to the Mental Health Field Services Bureau for Bureau and Department management review.

-Based on results of review, funds are allocated among regions.

-Contracts are written with each region to specify state and federal expenditure and program requirements.

-Monitoring of contracts is performed by the Bureau on an annual basis, including on-site visits along with Federal NIMH staff.

227 Part C - Facilities Assistance Funds

Should federal funds for mental health facilities assistance become available for fiscal year 1978, the Department will request 5% of those funds to assist in administration of the State Plan. The first application for funds will show the amount requested for administration and a categorized listing and explanation of federal and state funds to be used for administration of facilities development projects. Expenditures of state funds for this purpose in fiscal year 1968 were $2,000 (see Attachment 5). Further, not later than 60 days after the end of each fiscal year during which these funds have been expended, the chief of the Mental Health Field Services Bureau shall certify that federal funds for administration of facilities projects development have been utilized in accordance with the Act. A statement of actual expenditures by source and type will be included.

Methods used to distribute funds will be:

-Regional Mental Health Boards will be notified about availability of facilities assistance funds under Section 227 part C of the Act.

-Application for use of funds will be reviewed by the Mental Health Field Services Bureau and Department of Institutions management along with the Mental Health Advisory Council. A factor for approval of applications will be consistency with overall goals and objectives of the Montana Mental Health Services Plan.

-Applications recommended for approval will be reviewed and approved by the Health Systems Agency of Montana.

III

MONTANA COMPREHENSIVE MENTAL HEALTH PROGRAM

PRESENT STATUS

This section of the Plan is a general overview of the evolving Montana Mental Health Program. Over the past eight years there has been an increase in community-based mental health services. Programs have changed from the mental hygiene clinic concept with services located only in major cities to a regional mental health center concept with mental health services offered in most counties.

The centers are progressing toward services to a much wider array of disordered persons on a local basis. However, the change is not complete. Further improvements are required to insure uniform and accessible mental health services statewide. Services are not uniform due to differences in regional funding, population, and staffing patterns. Services are not as accessible as they might be as several counties are not financially participating in mental health programs. In addition, several required services such as day treatment, children's services and transitional care are provided in only a few of the larger counties.

Another significant change in Montana mental health services is the purpose of the State Mental Hospital. The current trend in the institution is away from custodial and toward therapeutic patient care.

The concept of therapeutic patient care is the essence of modern milieu therapy with early return of patients to the community when possible. This is primarily due to a growing awareness by the State Legislature and other interested persons of the dangers associated with prolonged hospitalization and an increasing disposition to seek other

ways of dealing with mental illness with community-based rather than institutional services. By virtue of short-term therapeutic care at WSSH patients are likely to be better able to fit back into their normal social roles and often they will receive ongoing treatment at a mental health center. By means of individualized patient treatment plans, frequent and regular utilization review and unitization by geographic units, the hospital is reducing the average length of stay. Improvements are also now being made in preadmission screening to alleviate inappropriate placement of persons with mental illness; and in diagnostic evaluation to deinstitutionalize inappropriately placed persons into less restrictive alternatives.

Overall, Montana is progressing in developing a responsive mental health program. However, as summarized below, during the next five years a significant amount of work is yet to be accomplished.

Statistical Overview

During the plan review process, Mental Health Field Services Bureau personnel performed a survey of existing mental health programs and facilities. The survey was limited to identifying the extent and nature of present regional mental health programs. No attempt was made to assess adequacy of regional operations in meeting the needs of current service populations. Rather, the purpose of the survey was to gain a broad perspective about the location of present facilities, services offered and volume of present populations living in counties which had some capacity for service provision. For the present planning effort, by identifying which services are available to regional populations, an overall analysis was done to determine priorities for new and expanded programs. Priorities were established based on two factors:

-The presence or lack of specific facilities or programs concentrating on target groups, and

-Discussions with regional mental health center staff about the nature and quality of present services.

Funding of Mental Health Centers:

The community mental health centers are funded from federal, state and local sources. Actual expenditures for state, FY '76, and estimated expenditures for state, FY '77 are shown in the following chart:

COMMUNITY MENTAL HEALTH CENTER EXPENDITURES

Actual '76	1	2	3	4	5	Total
Federal	$144,382	$ 585,754	$ 515,574	$248,860	$153,134	$1,647,702
State	331,216	376,361	371,741	347,058	289,567	1,715,945
Local	118,936	54,283	98,379	61,618	153,134	486,350
Total	$594,534	$1,016,398	$ 985,694	$657,536	$595,835	$3,849,997

Estimated '77						
Federal	$267,600	$ 673,936	$ 376,738	$256,767	$144,421	$1,719,462
State	382,647	475,731	477,178	432,019	404,883	2,172,458
Local	198,052	139,729	407,468	142,882	197,639	1,085,770
Total	$848,299	$1,289,396	$1,261,384	$831,668	$746,943	$4,977,690

The following summary describes in more detail present status of each service component of the Montana Mental Health Program. The summary includes:

1. pre-admission screening;
2. alternatives to hospitalization;
3. Warm Springs State Hospital; and
4. follow-up care.

Pre-Admission Screening

To eliminate inappropriate placement of persons in the Warm Springs State Hospital, the Forty-Fourth Legislature of the State of Montana passed legislation effective July 1, 1975 to provide for determination and treatment of the seriously mentally ill. This legislation parallels Federal Public Law 94-63 as it addresses the elimination of inappropriate placement in institutions of persons with mental health problems.

As defined in R.C.M. 1947, Chapter 13, Section 2, 38-1302(13), "seriously mentally ill' means suffering from a mental disorder which has resulted in self-inflicted injury or injury to others, or to the imminent threat thereof; or which has deprived the person afflicted of the ability to protect his life or health. No person may be involuntarily committed to a mental health facility nor detained for evaluation or treatment because he is an epiletic, mentally deficient, mentally retarded, senile or suffering from a mental disorder unless the condition causes the person to be seriously mentally ill within the meaning of the Act."

An effective screening program should have at least two major foci; community education and liaison, the regional mental health centers should notify courts and other relevant public agencies of the availability of the screening service and the design of legislation pertaining to commitment.

The patient evaluation process should be available to any appropriately identified person in the community who is being considered for institutionalization and should be based on the most comprehensive assessment practicable, including but not limited to psychiatric assessment, psychological evaluation and social history data.

Pre-admission screening is the mechanism by which a person is appropriately placed in the State Hospital or referred to a communty based treatment program. Community mental health centers are required to provide assistance to the courts and other public agencies in screening catchment area residents who are being considered for referral to the State Hospital in order to determine the appropriateness of such referral. Screening is also designed to identify persons for whom treatment through the center is an appropriate alternative to institutional care. Because it is apparent in R.C.M. 1947, Chapter 13, the courts should utilize the community mental health centers for screening persons prior to commitment to Warm Springs State Hospital, a meeting was held in June, 1975 for persons who would be directly involved with the commitment process. Specifically, the focus of the meeting was to inform judges, lawyers, and mental health personnel of appropriate entry procedures into Warm Springs State Hospital. While these early efforts have begun the implementation of R.C.M. 1947, Chapter 13, more work is required in consultation and education of judges and attorneys. At present, courts continue to by-pass mental health centers and commit persons to the State Hospital for 45-day court evaluations. Courts also frequently send persons directly to the State Hospital for 72-hour evaluations, even though the intent is clear in R.C.M. 1947, Chapter 13, Section 1305 (4-8) that a professional person should perform an initial interview in order to determine if an inpatient evaluation and treatment is warranted. Recent trends in admission statistics indicate that while emergency and involuntary commitments have decreased, court referrals have increased (See Exhibit 5).

EXHIBIT 5

WARM SPRINGS STATE HOSPITAL ADMISSION-DISCHARGE STATISTICS
Fiscal Year 1977

ADMISSIONS	REGIONS I	II	III	IV	V	TOTAL
Types:						
First Admissions	24	73	55	134	91	377
Re-Admissions	27	46	54	171	100	398
Others	77	218	116	376	245	1032
Placement Returns		1	1	8		10
Kinds:						
Court Order	41	74	38	70	87	310
Court Order Evaluation	12	31	28	56	41	168
Emergency			2	4	5	11
Transfer				1		
Voluntary	58	154	98	485	222	1017
Involuntary	17	79	60	73	81	310
TOTAL ADMISSIONS	128	338	226	689	436	1817
DISCHARGES						
Discharges	51	110	108	293	186	748
Home Visit - CVL - AWOL	65	191	95	341	230	922
Home Visit Placement	23	26	51	47	17	164
Death	8		6	9	4	27
Transfer	19	37	37	74	25	192
TOTAL RELEASES	166	364	297	764	462	2053
IN HOSPITAL CENSUS as of 6/30/77	60	84	82	160	104	490

Source: Daily W.S.S.H. Admission and Discharge Sheets

During the first eight months of 1975, 188 persons were referred by the court to Warm Springs State Hospital, however during the same eight months of 1976, 224 persons were referred. On the other hand, emergency and standard commitments represent the impact of the Regional Mental Health Centers and the new commitment laws as emergency commitments decreased from 207 to 25 and involuntary commitments decreased from 226 to 130 persons.

In addition to the above mentioned problem area, Warm Springs State Hospital has not been able to maintain a consistent admission policy as stated in R.C.M. 1947, Chapter 13, Section 3, 38-1303(2). Thus, persons continue to commit themselves to the institution without proper screening Inappropriate placement of persons in Warm Springs State Hospital are costly to the county of residence, and often infringe on the person's rights and human dignity.

Finally, there is only one formal, regional screening unit in the state. The unit is located in Region V, Missoula and opened in late February, 1976. It is a pilot project funded by 314(d) monies. (Grants to states for public health services - Section 314(d) Public Health Services Act, July 1, 1968 as amended.) The project includes a screening team consisting of a psychiatric social worker who is acting director, a psychologist whose function is training, part-time help from the staff psychiatrist, and senior and graduate students from the University of Montana who are enrolled in psychology, social welfare, and law. Stipends have been allowed to two graduate psychology students and to three social welfare students. Lectures have been given to the law school students by the psychologist trainer in regard to the State Commitment Law. Also, the Law School and the Mental Health Center jointly sponsored a workshop for lawyers, district and city judges, parole and probation

officers, Warm Springs State Hospital personnel, clinical psychology department personnel, and staff from the Regional Mental Health Center. The workshop received publicity from radio and news releases in the local newspaper. Although the original contract called for doing 90 evaluations in calendar year 1976, actually 171 were completed by December 31, 1976.

Thus, there is an apparent need for at least one screening unit in each region to do comprehensive assessments for persons with mental problems. It is essential that the professionals responsible for these assessments have appropriate training and experience, given the range of situations which may confront them.

In summary:

-Courts seem reluctant to use mental health centers for pre-admission screening.

-Warm Springs State Hospital has not been able to maintain a consistent admission policy in accordance with R.C.M. 1947, Chapter 13.

-Need for improved screening procedures in four of the five regions.

Alternatives To Hospitalization

Ideally, it is the Regional Mental Health Center's function to insure the availability and continuity of services for all persons with mental health problems and to mitigate hospitalization. It is currently within the realm of the center's capability to provide the original five (5) essential elements of service; inpatient, outpatient, emergency, partial hospitalization and/or day care, and consultation and education.

In addition to the five (5) original services, seven more service

elements have been mandated by PL 94-63, Section 201 (A-H). To reiterate, they are: children's services, services for the elderly, screening, followup care, transitional halfway houses, services for the treatment and prevention of alcoholism, and treatment and prevention of drug addiction and abuse.

In considering alternatives to hospitalization, the following narrative will summarize the status in Montana of both treatment and domiciliary programs for persons with mental health problems. For detailed descriptions of programs within each catchment area, see Appendix B.

Treatment

Inpatient Services

This service is designed to provide a therapeutic environment for persons with severe emotional problems who require 24-hour care. The thrust of inpatient care is to provide short-term, intensive treatment and/or evaluation in a humane manner which promotes and preserves the dignity of the patient. The focus of community mental health center inpatient units is active treatment, short stay, and carefully planned referral to the community with followup care and/or referral to the State Hospital if longer-term treatment is required. In general, inpatient service is utilized only when, and for so long as, other center services are not appropriate.

Overall three of the centers (Northern, South Central and Western) have affiliating agreements with local hospitals containing psychiatric units; the other two centers admit patients to local hospitals without psychiatric units. Overall, inpatient services are available in Montana. Results of

interviews with directors of regional mental health centers indicate that present local hospital bed capacity is not being used 100%.

During calendar year 1976, inpatient services were provided for 431 seriously emotionally disturbed persons. (State Mental Health Management Information System.)

Outpatient Service

This is the most widely used service in the regional mental health centers. It provides the necessary therapies for clients who can be maintained on this basis. Outpatient services are usually provided on a regularly scheduled basis. Clients are seen for non-scheduled visits during times of increased stress or crisis. Thirty-four offices are available on a full time basis throughout the state. Where resident satellite offices are not available, traveling staff members from neighboring counties visit once or twice a week.

It is not unusual for some centers to have waiting lists. This can be justified by lack of staff and number of admissions to service. For example, in calendar year 1976, there were 7,887 (State Mental Health Management Information System) admissions (new and reopened) to outpatient services across the State. Regional outpatient admissions were: Region I, 1,285; Region II, 1,229; Region III, 1,833; Region IV, 1,759 and Region V, 1,781 (State Mental Health Management Information System). The number of interviews, including individual, group, and family, totaled 45,473 (State Mental Health Management Information System) for this same time period.

Emergency Service

This service provides immediate health care and evaluation for persons in crisis on a 24-hour-a-day, seven-day-a-week basis. The regional mental health centers, at least in the regional central offices, have a mental health professional on call for either consultation or direct service, as needed.

The more populated communities have crisis telephone service manned by trained workers and/or staff members of the mental health center. A list of mental health professionals who are on call are available to the workers on the crisis telephone.

Also, it is not unusual for local hospitals or law enforcement agencies to call community mental health center professionals for emergency service. Most often, those individuals receiving emergency care are transferred to other services of the center, as their needs dictate.

Because of Montana's rural nature, emergency services are somewhat inadequate. This is due, in part, to the large geographical areas made up of several small cities and towns, with crisis telephone services located only in major cities. Persons residing in small cities and towns often are reluctant to call long distance for this service although some do use the service. However, professionals for the most part, located in the satellites are on call, but are not always available, to provide consultation and direct service for persons in a crisis situation. The Mental Health Advisory Boards have a strong role in publicizing and monitoring this service.

Day Treatment and Other Partial Hospitalization Services

The five Regional Mental Health Centers are currently providing some day treatment services for persons with mental health problems. Persons in day treatment have been discharged from Warm Springs State Hospital, private hospitals, or referred by mental health centers and other agencies.

Day treatment service is designed to provide a therapeutic program for those persons who require less than 24-hour a day care, but more than out-patient care. This service has proven to be an effective transition between full-time care and return to the community in Montana.

There are thirteen day treatment facilities available in Montana with services offered from 20-40 hours per week and open 3-5 days per week.

Although partial hospitalization can be effectively tailored to meet a range of patient needs and reduce hospitalization, manpower and funds have limited this progra To date, night care and weekend care facilities are not available. There are centers which provide group therapy during evening hours to meet the needs of special categories of clients.

Consultation and Education

Again, this service is minimally provided across the State which is largely due to lack of professional staff and staff concentration on direct services. The Regional Mental Health Centers are providing some consultation and education (C & F) to schools, courts, law enforcement agencies, and health services delivery agencies. The Montana Association for Mental Health does address the general public on the nature of mental health problems and types of services available but suffers from insufficient chapter development to cover all parts of Montana. However, there is little provision of C & E designed to:

1. develop effective mental health programs for special target groups in the center's catchment area;
2. promote coordination of the provision of mental health services among various entities serving the region;
3. increase the awareness of all residents in the regions regarding the nature of mental health problems and the types of mental health services available; and,
4. promote prevention and treatment of victims of rape.
5. training of natural providers.

In summary, on a statewide basis the above five original services are being provided. Inpatient services are in place and a wide array of persons are seen on an outpatient basis. However, there is lack of uniformity and accessibility primarily due to staff orientation, geography, and acceptance of mental health services by other agencies and the public. Some centers do, on occasion, have outpatient waiting lists. This problem could be alleviated by more staff in some regions, by extending office hours, and by utilizing more group therapy in lieu of individual therapy. For good emergency coverage, it may be necessary to establish more than one crisis telephone service in the catchment areas with toll-free telephone numbers listed in all the local directories serving the area. Day care services are not completely accessible. Although consultation and education services are available to most of the total population, there are gaps and areas which need improvement as pointed out in the above narrative.

Public Law 94-63, referred to as 1975 amendments to the Public Health Services Act, mandated provision of additional mental health services over the basic five previously discussed. As can be expected, Montana's Mental Health Program is currently undergoing revision to implement additional services. As described below, some regions have progressed further than others.

Specialized Services For Children

Children have always received care at Regional Mental Health Centers. However, due to the specific nature of their needs and specialized training needs to provide services, greater attention should be paid to programs for children.

There are special programs for children with emotional problems that have been federally funded in two of the five regions. Regions I and III have children's grants to provide consultation and education to schools, day care services for children, and group therapy for parents. Outpatient services for children are available in all five Mental Health Center Central offices and 28 satellites and workers skilled and experienced in children's work are employed. However, the centers are just beginning to have children's specialists who are assigned responsibility for managing the children's programs.

A full range of programs are needed to include children who are: abused and/or neglected; psychotic, acting out; or are suffering from emotional disturbances or organic disorders.

There are two private residential homes for children with emotional problems in the State located in Missoula and Billings. A special unit has been developed for children's treatment at Warm Springs State Hospital. It is expected that this will be an interim measure until comprehensive children's services can be developed more extensively in the community.

The Community Mental Health Centers Act of 1975 stresses that a Regional Mental Health Center must devote a meaningful portion of their resources to addressing the needs of children. Services for children should include the full

range of services made available by the center, appropriately geared to the needs of children at different stages of development. There is need for extensive coordination and collaboration with children's agencies and services throughout the state.

Specialized Services To Elderly

Programs for the elderly should address the full range of diagnostic, treatment, liaison, and followup services. Since for many elderly, opportunities for social contact are restricted, it is particularly important that followup services be carefully planned and implemented with the aim of maintaining therapeutic gains and reducing the impact of isolation. As many elderly citizens have little knowledge and awareness of mental health problems and very seldom voluntarily seek out services, an extensive mental health education thrust is necessary to really involve this segment.

Many elderly patients are being deinstitutionalized. The Regional Mental Health Centers are responsible for their placement and treatment. This service has been funded in the past from a contract between the Department of Institutions and the Regional Mental Health Centers. There are few formalized programs specifically for the elderly other than placing inappropriately housed patients from Warm Springs State Hospital into nursing homes, but most centers do provide transportation, include patients in day treatment and consult with nursing homes. There is a beginning attempt to assign specific responsibilities to one person in the center and a plan of action drawn up.

Services For The Alcoholic

There are alcohol programs in the five regions but not on a uniform basis. Because alcoholism is a problem for many mental health clients, an effort has been made to coordinate the alcohol programs with mental health services by the Department of Institutions. Some Regional Mental Health Centers have good

working relationships with alcohol programs but there is need for more co-operation in most regions. The coordination-of-planning section of this plan contains a complete description of the conjoint effort between the Bureau of Addictive Diseases and the Mental Health Field Services Bureau to coordinate Regional Mental Health Centers and alcohol programs.

Services For the Drug Abuser

Only Region III, IV & V have a comprehensive program for the prevention and treatment of drug abuse and drug addiction. During calendar year 1976, 628 clients were enrolled in these three Programs. A conservative estimate of persons in Montana with drug problems is 1500. However, the number is probably closer to 3,000 drug abusers in the State. During Fiscal year 1976, the Mental Health Centers admitted 206 persons with drug problems for treatment (this figure includes primary and secondary diagnosis). The regional admissions are as follows:

Region	Admissions
1	12
II	14
III	44
IV	9
V	127

Regional Mental Health Centers are responsible to provide a service program for drug abusers if there is sufficient need for the program. An overall objective of the Adaptive Services Division is a coordinated drug abuse, alcoholism and mental health service program. To date, most efforts at

coordinated drug abuse programs have been statewide training workshops for Community Mental Health Center Staff made available by the State Drug Abuse Treatment Agency.

Transitional Services (Community-Based Residential Treatment Facilities)

All five catchment areas have transitional care facilities with two in region V, two in region IV, two in region II, five in region III and two in region I. Further development of this service is an urgent priority to maintain continuity of care for discharged institutional patients. New resources need to be developed in communities to provide the very important transitional homes. It is a fact, that many patients would not have to live in the State Hospital if alternate living accommodations could be located near treatment services. Transitional homes do provide continuity of care to many deinstitutionalized Warm Springs State Hospital patients and alleviate inappropriate placements into Warm Springs State Hospital.

To date, a temporary licensure procedure for mental health transitional homes is in effect. Several meetings have been held with the Department of Health and Environmental Sciences, Division of Food and Consumer Safety Bureau. A strategy for drafting proposed legislation is being developed which will accomplish permanent licensing standards for transitional homes.

Initially, residents of transitional care facilities tend to be usually frightened and uneasy after many years of institutionalization. Usually, they attend day treatment and sheltered workshops and can make good progress in independent living skills.

A variety of forms of transitional care has developed in Montana. Region III operates three group homes in conjunction with the Deaconess Hospital and has two community cluster homes for more independent living. In region V, an independent boarding home is contracting with the mental health centers and providing care for five patients from Warm Springs State Hospital. In region II, the center has contracted with Salvation Army to provide care for 15 patients from Warm Springs State Hospital. In addition the Downtowner Hotel is working closely with the center and providing care for five patients. Region IV has its own group home. Region I has two group homes, one of them adjacent to the general hospital. All of the regions are consulting with those private nursing home facilities which have taken patients from W.S.S.H. and provide direct service as requested.

The Center for the Aged, owned and operated by the Department of Institutions, is a long term care facility capable of providing skilled, intermediate A and intermediate B levels of care and treatment for a resident capacity of 202 patients as prescribed by Title XVIII and Title XIX of Medicare.

The staff of 70 in number provides an open campus, home-like environment to residents who must, by law, be referrals from the State Mental Hospital at Warm Springs or Mental Health Centers and who must also be ambulatory and over 60 years.

Follow-up Care

The State Mental Health Authority is required to provide assistance to the Regional Mental Health Centers to facilitate follow-up care and/or follow along for residents who have been discharged from mental health facilities. This requirement is designed to assure adequate community support for those

no longer in need of inpatient care, outpatient and day treatment with particular emphasis on the needs of patients discharged from Warm Springs State Hospital.

Under the terms of a specific cost-for-service contract between the 5 centers and Warm Springs State Hospital, each regional mental health center has delegated responsibility to a staff unit for follow-up care. Predischarge planning procedures are instituted at Warm Springs State Hospital involving the regional mental health staff member, Warm Springs State Hospital social workers, and the Department of Social and Rehabilitation Services. The team discusses patient needs and community resources and submits a formal treatment plan. A formal treatment plan is necessary for all discharged patients. The Department of Social and Rehabilitation Services has been, and is, involved in placements and other community referral mechanisms are utilized. The case management system is interlocked with the formal treatment plan and assures treatment and domiciliary needs are being adequately addressed for each discharged Warm Springs State Hospital patient who was a patient at the hospital on July 1, 1975. Evaluation and monitoring of the contract is done by the Mental Health Field Services Bureau.

The responsible centers in each catchment area in the state are Eastern Montana Community Mental Health Cntr. - Miles City, Northcentral Montana Community Mental Health Cntr. - Great Falls, South Central Montana Regional Mental Health Cntr. - Billings, Southwest Montana Mental Health Cntr - Helena, and Western Montana Regional Mental Health Cntr. - Missoula. Their follow-up personnel are responsible for the follow-up procedures throughout the regional mental health center catchment area.

Although the contract between Warm Springs State Hospital and the centers terminated on July 1, 1977, the legislature included the above mentioned services into the general fund appropriation for the FY 78-79 biennium but at a decreased level.

Joint planning between the Department of Social and Rehabilitation Services, Division of Developmentally Disabilities and the Department of Institutions, Division of Adaptive Services, has spelled out criteria for provision of community services for the developmentally disabled who are presently at Warm Springs State Hospital.

Minorities Services

The major minority group in Montana is Native Americans. There are seven Indian reservations. The Bureau of Indian Affairs does operate some minimal mental health services on the reservations but there is a need for more extensive services that will also cover the off-reservation Indians. Regions I and III mental health centers have contracts with reservations whereby Indian paraprofessionals are hired by the tribe to work full time on the reservation but obtain supervision and consultation from the center. Region V has a Ph.D. psychologist working almost full time on the Flathead Reservation. Region II and III offer services on an as-needed basis. However, the mental health needs of Montana's Native Americans are not being met to the level needed. The Mental Health Field Services Bureau contract for FY 78 calls for more extensive coverage in the coming year with a full time qualified professional being responsible for Indian services and development of a plan to extend services in a meaningful manner.

Rape Services

Prevention of rape and services to victims of rape is mandated by P.L. 94-63. In four of the regions volunteer organizations have been developed and the centers do consult with, provide training to and assist as needed. In region I where no such agency exists the center has an ongoing relationship with the police who do call and refer as needed for services and the center is planning workshops for the police in the coming year.

Public Mental Hospital

Title 38, Chapter 13, R.C.M. 1947 defines the process for entry into Warm Springs State Hospital by persons suffering from serious mental illness. The institution's primary concern is to provide inpatient care and intensive treatment to mentally ill persons. State hospital care is seen as a vital link in the total chain of mental health services.

Warm Springs State Hospital has regionalized its facilities to correspond with the regions of the State. There are five regional units for patients committed from the catchment areas. In addition there are special units for children, geriatrics, forensics, physically ill, schizophrenic patients and the mentally retarded. (Exhibit 6 displays a schematic of hospital grounds and facilities). Region I patients are housed in the general hospital building (27,28,29). Units 66 and 67 are utilized for Region II patients. Receiving hospital, wards B2, C3 and D4 house Region III patients. Region IV patients are housed in Bolton building 52,53,54 and 55 and Region V patients are in the Mitchell Building (33,34,35). These facilities consist primarily of large dormitory areas and some are in the process of or are scheduled to be remodeled to comply with Medicare/Medicaid standards. The Forensic Unit (security 56 & 57) security building provides a secure environment for court referrals who are sent to the institution for evaluation. Geriatrics patients are housed in the G219, which is a one-story building containing semi-private rooms, rehabilitation therapy areas, and dining area. Building 219, completed on October 26, 1976, was designed for geriatric patients. The hospital and community mental health centers are participating in a joint effort to place all geriatric patients who do not need intensive psychiatric care and treatment in community rest homes and nursing homes. Mentally retarded patients are primarily housed in the Mussigbrod Building (49,50) which is comprised of large dormitory areas and individual areas on the second floor for patients who are dangerous to self or others. These areas are also utilized for women court referrals who are committed for evaluation.

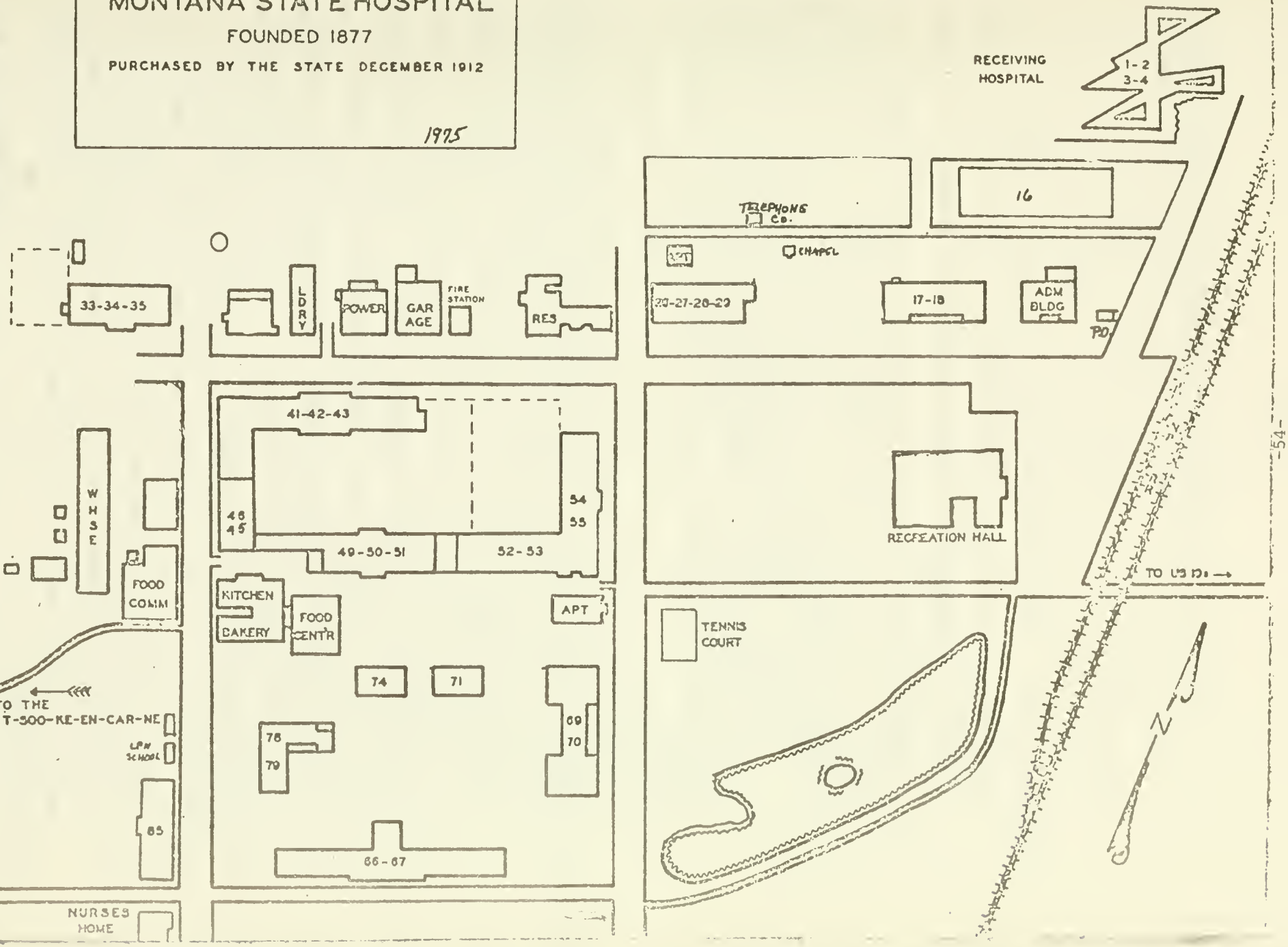
EXHIBIT 6

MONTANA STATE HOSPITAL

FOUNDED 1877

PURCHASED BY THE STATE DECEMBER 1912

1975



The intensive treatment unit opened May 31, 1977 for rehabilitation of schizophrenic patients and is located in receiving hospital Ward A-1. Exhibit 7 displays the present population of residents for each program.

The hospital has set up its own Reality Orientation program which offers consultation and educational services to various regions including rest home and nursing home facilities in those areas. It is anticipated that with the introduction of reality orientation into many of our nursing homes and rest homes throughout the state a more viable program will be offered there for many geriatric patients. The hospital has traditionally had a large number of mentally retarded patients for whom the service provided has been primarily institutional care.

Since August 1976, an individual treatment plan has been devised for each mentally retarded patient with educational services being provided. In September 1976, an individualized diagnostic evaluation work-up was completed and referrals for placement were forwarded to Boulder River School & Hospital. Further work is being done to expedite this referral.

A children's unit opened July 15, 1976. Unit 85 has been remodeled for the children's program and is comprised of several four to six bed wards. It has a capacity of 40 with a population of 31, 20 male and 11 female as of June 14, 1977. This program is planned to be an interim service until comprehensive children's services can be developed in the community.

Each unit within the hospital has a treatment team consisting of a psychiatrist, psychologist, social workers, rehabilitation therapists and nursing personnel. The professional personnel form a team for the purpose of evaluating the patient on admission, planning the treatment program, monitoring the patient's progress, and changing the treatment program as indicated. The treatment team provide an eclectic approach with the use of psychotropic medications, individual counseling, group work, or a number of other approaches such as behavior modifications and reality orientation. There are some programs available to all patients

EXHIBIT 7

WARM SPRINGS STATE HOSPITAL
PATIENTS BY SPECIAL UNIT

June 14, 1977

SPECIAL UNIT	TOTAL POPULATION (1974 Estimate)	BED CAPACITY	PRESENT RESIDENTS MEN	WOMEN
Region I	95,100	62	24	18
Region II	147,400	80	24	22
Region III	144,800	84	38	25
Region IV	178,200	130	58	40
Region V	169,300	105	40	23
SUBTOTAL		461	184	128
Children's Program		40	20	11
Forensic		46	24	0
Geriatric		64	25	24
Mentally Retarded		40	19	15
Medical/Surgical		37	12	7
Intensive Treatment Unit		20	8	2
SUBTOTAL		247	108	59
TOTAL		708	292	187

Total Patients in Hospital	6/14/77	479
Total Patients in Hospital	7/1/75	904

under the general heading of rehabilitation therapy, which include occupational therapy, recreational therapy, basic education, industrial therapy, educational counseling, vocational education programs, music therapy and library services.

Medical/surgical services are available as needed by patients. The institution has a well-equipped laboratory for various blood and tissue tests and is equipped with x-ray, electrocardiograph, and electroencephalogram machines.

It is the intent of the institution to improve the quality of care for patients by improving psychiatric treatment modalities and to provide an active treatment program for each patient. It is possible to achieve this by continuing education and consultation services of the University of Washington School of Medicine for the present staff. Highly trained personnel should be hired as the need arises for new staff and/or staff replacements and positive incentives shall be utilized to facilitate this.

Pursuant to the aforementioned regionalization, a liaison has been formed between the Regional Mental Health Centers and Warm Springs State Hospital. Teams from the Regional Mental Health Centers and the treatment team from Warm Springs State Hospital meet frequently to: a) implement treatment plans for patients who are to be placed in a less restrictive environment and b) to coordinate admissions of proposed patients. The hospital team also makes visits to the various regions for consultation. These meetings between hospital and center staff develop mutual awareness of hospital and community mental health programs and thus they can more adequately plan for patient's services. Community facilities must be adequate before releasing patients.

To comply with R.C.M. 1947, Chapter 13, the commitment law, Warm Springs State Hospital has completed a treatment plan for each patient which includes goals and time specific objectives. Medical histories are obtained within 4-8 hours of admission. All admissions are provided psychiatric examination, social services, psychological evaluation, and occupational assessments. Aftercare plans are developed when appropriate. Patient rights and needs are taken into account.

In summary, Warm Springs State Hospital was reorganized into regional and special units in September, 1975. Regionalization has supported liaison between the institution and the Regional Mental Health Centers; thereby greatly improving the cooperative relationship. Some buildings are being modernized and renovated to meet Medicare/Medicaid Standards. New methods of treatment have been implemented, and there is constant effort being made to improve treatment methodologies.

Board of Visitors

The Board of Visitors is the watchdog agency for the mental commitment and treatment act. The Board is appointed by the Governor and is administratively tied to the Governor's Office.

Its purpose is to assure that the treatment of all persons voluntarily admitted or involuntarily committed to a mental health facility is humane and decent and meets the standards established by the act R.C.M. 47 (38-1330(2)). The Board makes an inspection at least annually of every mental health facility within the state which is providing evaluation and treatment for mentally ill persons. This inspection includes overview of the physical plant, including residential and treatment areas, and an inquiry into general and individual treatment plans being used in the facility. The Board of Visitors assists residents at mental health facilities to resolve any grievances they may have concerning their commitment or course of treatment.

If the Board of Visitors determines that a mental health facility is failing to comply with the requirements of the mental commitment and treatment act in regard to its physical plant, or the care or treatment of residents, it reports its findings to the next of kin or guardian of any patient involved, the responsible person appointed by the court for any patient involved, the professional person in charge of the facility, the director of the department of institutions, and the district court which has jurisdiction over the facility. The Board makes an annual report to the Governor and reports to each regular session of the Montana Legislature (38-1330(8)). The Board may hire staff to assist it in carrying out its duties (38-1330(9)).

Mental Health Association of Montana

The Mental Health Association of Montana is a volunteer organization concerned with improving the mental health of citizens of Montana. The Association is part of a three-level structure which is composed of the National Association for Mental Health (headquarters in Arlington, Virginia), State

Associations and local chapters. The state association is located in Helena. There are currently 12 local chapters of the Association in Montana: Anaconda, Blaine County, Cascade County, Daniels County, Gallatin County, Helena, Miles City, Molt, Pondera County, Sheridan County, Silver Bow County and Yellowstone County.

The Mental Health Association of Montana is governed by a 24-member Board of Directors. The Board is composed of citizens representing the five mental health regions. The staff consists of an executive director, a field representative and a secretary.

The mission of the Mental Health Association via research, social action and education is:

1) Prevention of mental illness;

2) Promotion of mental health; and

3) Services for those in need.

During 1978, a public relations campaign will be initiated by the Association to aid in alleviating the stigma of mental illness and to educate the public about the work of the Association. Also, volunteers will be involved in assessing mental health needs in their communities and reviewing mental health centers.

Cooperative efforts will be made to coordinate endeavors shaped by the Bureau of Mental Health, Governor's Mental Health Advisory Council, and the Mental Health Centers.

Priorities for Expanded Mental Health Programs

Over the next five years, each of the above current problem areas are in need of improvement. The state agency has outlined six major priorities for mental health programs. They are:

-transitional residential services including group homes, half-way houses, etc.

-services to children and the elderly

-day treatment services

-pre-admission screening for assistance to courts and other public agencies in making referrals to Warm Springs State Hospital.

-followup care for discharged institutional patients.

-Improvements in the quality of care at Warm Springs State Hospital.

It is important to recognize that these priorities can be implemented only if there is sufficient funding available. In addition to the above priorities, there is a limited amount of service coordination for the Native American. Although reservation Indians receive mental health services from the Indian Health Service, programs for urban Indians are in need of further coordination between mental health centers and other Indian programs. Ideally, due to cultural differences, an Indian counselor should be on staff for consultation with the Indian Health Service and other agencies. His role will be to counsel the urban Indian and coordinate special programs for this target group. Finally, based on results of the "needs survey" (see Appendix A), the rank among regional catchment areas for the most relative and potential need for mental health services is as follows:

	Rank	Region
(Highest Need)	1	I - Eastern Montana
	2	V - Western Montana
	3	II - North Central Montana
(Lowest Need)	3	III - South Central Montana
	3	IV - Southwestern Montana

The ranking on the indicators of need for mental health services and the availability of resources will provide guidance to the state, and local centers

in the planning, development, and resource allocation for mental health services. This ranking will be shared with affected centers and with the mental health advisory council to obtain input on limitations and applicability of results, prior to use for funding decisions or recommendations.

The Mental Health Field Services Bureau offers technical assistance for the development of grant applications at the local level in areas of high need. As mental health centers have been developed across the country, they have tended to develop first in areas of relatively low need because high need areas have often not had the manpower and expertise to develop grant proposals. Montana has the opportunity to avoid this common pattern and to stimulate resource development for high need areas.

Montana has done well in obtaining original federal staffing grants and getting mental health centers started. It is one of the few states in the nation to obtain federal staffing grants covering the whole state. To facilitate the centers development of federal conversion grants, grants that allow the centers to expand from five to twelve services, the Mental Health Field Services Bureau has developed a ranking scale based upon "The Social Condition and Social Service Target Populations of Montana's Counties, 1977." This is a needs assessment study done by Department of SRS - in conjunction with Title XX Plan preparation. This ranking is found in Attachment 6.

With these priorities in mind, the following mission statement and goals and objectives have been outlined to help insure mental health for all persons residing in Montana.

MISSION STATEMENT

A primary mission of the Department of Institutions is to facilitate the provision of an integrated network of comprehensive mental health services on an equal basis throughout Montana. These services shall be based upon demonstrated needs, attested to by its citizens and will include both direct and indirect services. Services of high quality at the least cost possible will relate to rural-oriented guidelines and standards as appropriate.

GOALS AND OBJECTIVES

The Montana Department of Institutions has the overall responsibility for coordination of mental health programs supported by local, state and federal funds. In order to assure optimal responsiveness to the needs of Montana citizens, it is necessary to have an ongoing planning process which sets forth the major philosophical and operational direction of the program and which identifies the action steps required to achieve desired ends.

Further, progress toward meeting needs of citizens must be monitored on a regular basis. Thus, the goals and objectives outlined below provide a mechanism for future planning and evaluation. They are intended to communicate to federal, state and local organizations the overall direction of the Department of Institutions in further development of mental health services. Objectives by their very nature are planned or desired outcomes. For each of the next five years, objectives of this plan will be reviewed in-depth with increased state agency capacity to evaluate program results. As this occurs, increased knowledge of population needs and service resources will be available and may cause revision of present objectives.

The Department mission and purpose, which establish the foundation for the state public mental health delivery system, are reflected in the following goals, principles, and objectives. The goals represent a unifying force that is intended to integrate the various elements of the plan. As each goal is interrelated and inter-dependent upon the others, their order of listing does not indicate relative priority.

The following objectives are intended (a) to describe the necessary steps toward accomplishment of the stated goals, and (b) to provide a means of assessing progress. Unlike goals, which should remain relatively constant, these objectives may reflect the principle of flexibility as they respond to changing needs, resources, and other factors that evolve during the continuous planning process.

GOALS 1-4

#1. To preserve and maintain the orderly development of a unified and integrated statewide mental health service delivery network that would include community based mental health services, Warm Springs State Hospital, and other state-supported institutional programs serving the mentally disturbed or disabled.

#2. To provide high quality developmental and rehabilitative services within state administered programs which emphasize the following features of deinstitutionalization:

- least restrictive environment
- appropriate institutionalization
- improved institutional care and treatment
- provide for planned community-based alternatives

#3. To increase and improve services to mentally ill persons and to promote mental health for all citizens of Montana through:

- increased consultation services
- increased public knowledge of mental health services
- increased preventive activities
- improved manpower development and training

#4. To provide a unified comprehensive mental health network of services which:

- is cost-effective and financially accountable
- is efficient and based on specific area needs
- establishes and enforces quality of care standards
- is evaluated

GOAL #1:

To preserve and maintain the orderly development of a unified and integrated statewide mental health service delivery network that would include community based mental health services, Warm Springs State Hospital, and other state-supported institutional programs serving the mentally disturbed or disabled.

The intent of this goal is to stress the principle of cooperation as a basic value in the orderly development of mental health programming in a rural state. The goal emphasizes the strengths of a single, unified effort to insure the health and safety of individuals in the care and custody of the state-supported community mental health centers, the State Hospital, and/or other institutional programs. The sharing of services among or between the five CMHC's and between the Centers and WSSH is encouraged. Conversely, the principle of competetiveness for clientele or for limited resources is viewed as counter-productive to the achievement of this long-range goal.

OBJECTIVES

1. By April 1, 1978, a joint treatment planning group to formulate and develop diagnostic, admission, treatment and discharge policies will be formed. The initial purpose of this committee will be to create open dialogue surrounding mutual problems, definition of terms, and other inter-related concerns and issues. (Responsible Organization: Mental Health Field Services Bureau).

2. By July 1, 1978, specific plans, policies, and procedures will be implemented for transfer of patients between the Hospital (WSSH) and the community mental health centers (CMHC's), and among the CMHC's. It is expected that this staff-level agreement will be an extension of the basic Commitment Law and will provide procedures and mechanisms for uniform, effective, and orderly transfer of individuals anywhere in the state as appropriate to care or treatment needs. (Responsible Organization: WSSH & CMHC's).

3. By July 1, 1978 will be developed, a common patient information system appropriate to all mental health agencies in the state, concerning such issues as patient movement, patient tracking-transfer; records, etc. By July 1, 1979, to have this data-base system fully implemented. (Responsible Organization: CMHC's and WSSH with Mental Health Field Services Bureau (MHFSB) coordinating)

4. By April 1978, each Center will have developed and implemented written procedures for the pre-screening of potential admissions to WSSH including methods to be used to publicize center's availabilities for screening. (Responsible Organization: CMHC's)

GOAL #2:

To provide quality developmental and rehabilitative services within state administered programs which emphasize the following features of deinstitutionalization:

- least restrictive environment
- appropriate institutionalization
- improved institutional care and treatment
- provide for planned community-based alternatives

The expectation of this goal is to establish the principles and processes of deinstitutionalization as defined by the Montana State Plan. The term deinstitutionalization is a verbal referent to three basic principles of mental health care in state administered programs: (a) inappropriate hospital admissions should be prevented through the provision of community alternatives to treatment; (b) all institutionalized persons who have been determined capable of community care and have been given adequate preparation for change to a less restrictive environment; and (c) the establishment and maintenance of community support systems for non-institutionalized persons receiving mental health services in the community.

This definition of deinstitutionalization assumes a reduction of institutionalized patients at Warm Springs State Hospital, but also improved services for the remaining appropriately institutionalized patients. The principles of "least restrictive environment", "appropriate institutionalization", and the provision of a full-range of community-based alternatives, should prevail.

The accomplishment of this goal requires:

a. recognition of the CMHC's and mental health private practitioners as the primary point of entry for clients entering the public mental health system;

b. pre-admission screening to insure that clients are not admitted to inpatient or other more intensive level of care than is required to effectively and efficiently treat them;

c. the development in each catchment area of the array of mental health services necessary to meet the service needs of the residents as mandated by P.L. 94-63;

d. the use of Warm Springs State Hospital for inpatient care and treatment for forensic psychiatric care and evaluation, specialized inpatient services to children and adolescents, and for other "appropriately institutionalized patients", i.e., those with psychiatric

disorders requiring long-term specialized hospitalization. This will require development of specific criteria to be used as the basis for selection of the appropriate treatment setting, and the movement of a client from one setting to another;

e. alternate treatment facilities including skilled nursing facilities (SNF), intermediate care facilities (ICF), residential care facilities, and day treatment programs will be developed and/or maintained in the five catchment areas. The availability of these facilities and preadmission screening are expected to reduce the inappropriate placement of patients at WSSH.

OBJECTIVES:

1. By January 1, 1978 individual treatment plans on each patient at WSSH will be monitored quarterly to determine those patients inappropriately admitted and/or housed at WSSH. (Responsible Organization: WSSH)

2. By January 1, 1978 a system of peer review and/or quality assurance of professional care and treatment will be developed by WSSH with the assistance of the University of Washington.

3. By April 1, 1978 a multi-discipline team will begin functioning on a quarterly basis for purposes of peer review, and/or quality assurance of professional care and treatment at WSSH. (Responsible Organization: WSSH)

4. By September 1, 1978 an annual update of existing CMHC services for statewide accessibility to institutional alternatives will be performed. This updated review of services will reflect the following list of statewide priorities: (Responsible Organization: CMHC Boards)

a) Transitional Services: (1) By July, 1978, at least two community based transitional care facilities in each catchment area, (2) By July, 1979, at least three community based transitional facilities in each catchment area. Facilities will meet state and federal regulatory and licensing standards.

b) Specialized Services for Indians, Children and Elderly: By March, 1978, each CMHC will begin semi-annual reports on current status of those services based upon needs assessment data and a description of program resources for each target population.

c) Day Treatment: By June, 1979, each CMHC will have developed at least one day treatment program in those communities (towns) with sufficient population to effectively conduct and justify such programs.

d) Services Close to Home: By July 1, 1978 each Center will have developed the full range of the twelve comprehensive services (inpatient, partial, outpatient, 24-hour emergency, consultation and education, pre-admission screening, transitional care, follow-up or aftercare and program services to children, rape victims, the elderly, Native Americans, and alcohol and drug abusers). These services will be provided directly or through affiliated agencies.

e) By June, 1978, each Center will have identified chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

f) By January 1, 1979 each Center will have begun providing services to chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

g) By November 1, 1978, a planning document will be developed for two psychiatric nursing facilities to accommodate individuals unable to receive appropriate treatment in existing nursing home facilities.

h) By July 1, 1978, toll free telephone emergency service will be provided throughout each catchment area.

5. By June 1979, an action plan and request for financial support will be submitted to the State Legislative Session (responsible organization: M.H.F.S.B.).

GOAL #3:

To increase and improve services to mentally ill persons and promote mental health for all citizens of Montana through:

- increased consultation services
- increased public knowledge of mental health services
- increased preventive activities
- improved manpower development and training

Consultation services primarily refers to the assistance given other human services professionals in the assessment of their attitudes and improvement of their skills in working with mentally ill persons and their families. These professionals include school personnel, court and law enforcement personnel, public health nurses, social service workers, agricultural extension workers, clergymen, physicians, and others. These individuals are on the front-lines of providing for the communities' mental health needs and logically should look toward the CMHC's for consultation and training services. The more that their attitude toward mental health needs and services are shaped by understanding and awareness, and their own skills improve in working with the various categories of mentally ill persons, the more effective they will be in the areas of early detection, early diagnosis, and early intervention. The prevention of serious mental health problems and more appropriate referrals to both the CMHC's and the state hospital should result.

Preventive educational services should also be directed at many potential victims of mental illness. Many of these people will not be noticeably disturbed, but nevertheless, are functioning below their potential capacities. This goal is intended to promote mental health in individuals, families, and communities by helping local citizens acquire knowledge, understanding attitudes and behaviors that will foster their own and the community's mental well-being. The intent of this goal is to support primary and secondary intervention at the local community level, not as a less important adjunct to traditional direct service methods, but as an equally important mental health provision towards prevention: Major areas of concern to be addressed are the determination of what modalities are best to prevention at the community level, the lack of data on the impact of preventive programs, and how specific problems of the aged, children, and ethnic minorities (most significantly the Indian population) can be addressed effectively.

Manpower development and training needs are considerable throughout the state, and even in the rural outreaches of this rural state. A special effort should be made as a first step towards the business of prevention by direct and aggressive confrontation with the various issues related to manpower development.

OBJECTIVES:

1. By January 1, 1978, all CMHC's will have one person (or shared responsibility among two or more area staff where necessary) identified as the center contact person responsible for Consultation & Education Services.

2. All CMHC's will have developed by July 1, 1978, a planned program for Consultation & Education that incorporates aggressive reaching out to other human service groups in the catchment area that includes provision to the Mental Health Field Services Bureau of a statement of regional Consultation & Education (C&E) needs, i.e., specific C&E topics of concern that are especially relevant to local problem areas. (Responsible Organization: CMHC Boards)

3. By July 1978 all centers will have demonstrated that one or more informational sharing/mutual consultation sessions with court personnel and law enforcement staff concerning areas of shared responsibility and coordination of mental health services have taken place within each Judicial district. (Responsible Organization: CMHC Boards)

4. By January 1978, the Mental Health Field Services Bureau will have begun to conduct one joint public information activity with the Mental Health Association of Montana each year. (Responsible Organization: Mental Health Field Services Bureau and Mental Health Association)

5. By March 1978, the Mental Health Field Services Bureau will provide periodic releases to local news media on various aspects of mental health in Montana. (Responsible Organization: Mental Health Field Services Bureau)

6. By August 1977 all CMHC's will be invited to submit proposals for governing and advisory board training programs. At least one proposal will be approved for funding with 314(d) monies. (Responsible Organization: Mental Health Field Services Bureau)

7. By September 1978, the Mental Health Field Services Bureau will initiate an assessment of C & E services within the state. (Responsible Organization: Mental Health Field Services Bureau)

8. By January 1978, the Mental Health Field Services Bureau will have conducted one or more interagency mental health manpower training team meetings composed of participants from related state administrative departments, including the Office of the Governor, and the State Institutions

of Higher Learning toward development of specific goals pertaining to mental health manpower needs in Montana. (Responsible Organization: Mental Health Field Services Bureau)

9. By March 1, 1978, the Mental Health Field Services Bureau will have articulated specific manpower goals and objectives in cooperation with related departmental agencies of state government and appropriate institutions of higher learning in the state. (Responsible Organization: Mental Health Field Services Bureau)

GOAL #4:

To provide a unified comprehensive mental health network of services which:

- is cost-effective and financially accountable
- is efficient and based on specific area needs
- establishes and enforces quality of care standards
- is evaluated

Sound management principles are essential to effective and responsible mental health services. These principles include an objective determination of need; the aggressive seeking of alternate sources of funding; the provision of effective services in the most efficient manner; and the evaluation of the impact of the services. Also necessary to this process is meaningful coordination with the state hospital at Warm Springs, other CMHC's, and with other agencies delivering services which have a bearing on the mental health of individuals and communities; and the existence and enforcement of standards.

A long-range aspect of this goal is the continued development of a sound base of fiscal support for the mental health system which will rely on the utilization of

a combination of funding sources including federal, state, local, third party, appropriate fee collections, and other potential funding sources. The principle of multiple-funding attempts to insure an adequately sound base for program maintenance and development, and to insure the local integrity and individuality of each catchment area.

The intent of this goal is to insure quality services and effective and appropriate evaluation while maintaining a genuine respect and support of the concept that administrative control and decision-making should be kept as close as possible to the point of production, i.e., the center level. An effective state evaluated program should recognize responsibility to insure relatively equal services to all Montana citizens while permitting appropriate flexibility in recognition of differential catchment area needs and resources. A future cost-for-service formula for state funding is planned with the expectation that such a funding formula will accomplish best the desire for (a) equal quality services that are uniformly evaluated, and (b) local autonomy to administer and provide those services as deemed best by local center administrators and clinical personnel.

OBJECTIVES:

4. By January 1978, State mental health institutions and CMHC's will develop a uniform management information system that includes financial data that is compatible with state and federal reporting requirements. (Responsible Organization: CMHC Boards, MHFSB and State mental health institutions)

2. By January 1978, each CMHC will develop a cost-per-service analysis of its operations according to guidelines developed by the State Mental Health Field Services Bureau. (Responsible Organization: CMHC's and Mental Health Field Services Bureau (MHFSB))

3. By January 1978, all CMHC's will have compelted a major on-site state-federal evaluation and each center will receive one less intensive

follow-up evaluation approximately six months after the initial evaluation, at which time deficiencies noted earlier will be corrected or accounted for. (Responsible Organization: Mental Health Field Services Bureau and CMHC Boards)

4. By January 1978, each center having participated in the development of a standards document for CMHC services will have developed an agreed upon basis for establishing a minimum level of compliance with the standards. (Responsible Organization: Mental Health Field Services Bureau, CMHC's)

5. By January 1979, each center will have demonstrated compliance with each and all of standards produced at least at the agreed upon minimum level. (Responsible Organization: CMHC Boards)

MANPOWER REQUIREMENTS

1. Summary of Current Workforce

The following table provides a listing of all personnel working at Warm Springs State Hospital, the five Regional Community Mental Health Centers, and the Department of Institutions Mental Health Field Services Bureau (State). The table does not list additional personnel at the Center for the Aged which also provides care to some identified patients formerly from WSSH.

DISCIPLINE	M.H.F.S.B.	WSSH	CMHC	Total
M.D., Psychiatrist		7	12	19
M.D., Non-Psychiatrist		6	2	8
Nurse, M.S.		2	2	4
Nurse, R.N. and B.S.		8	4	12
Nurse, R.N.		31	9	40
Nurse, Practical		72	1	73
Mental Health Worker AA			2	2
Mental Health Worker BA			9	9
Social Worker, M.S.W.	2	5	30.5	37.5
Social Worker, B.S.W.		12	10	22
Psychologist, Ph.D.	1	3	32.5	36.5
Psychologist, M.A.		16	25.5	41.5
Other Doctorate Level		2	5	7
Other Masters Level		14	15.5	29.5
Other Bachelor Level		24	19	43
Other AA Level		4	1	5
Other		548	96.5	644.5
TOTAL	3	754	276.5	1,033.5

The table does not reflect full or part-time personnel separately; however, the rough data collected for the report does show that 102 or 10% of the total number of people working in the mental health system are part-time.

Included in the "other" category are:

Teachers

Administrative Officers

Clerical and Secretary

Physical Plant Managers

Craft (plumbers, painters, etc.)

Food Service

Medical Records

Dietitians

Occupational Therapists

Pharmacy

Labor and Grounds Maintenance

2. Projection of Personnel Needs

Requirements for providing an adequate supply of appropriately trained mental health personnel is a serious challenge in sparsely populated rural states such as Montana. This problematic area will likely become even more difficult for Montana during the coming two years. Legislative funding for WSSH and the CMHC's has been less than desired resulting in some staff layoffs at the hospital and little opportunity for needed personnel expansion at the community level. Two developments capture the ultimate outcome of the FY 78-79 funding period: (a) services provided at WSSH will remain in place but with fewer staff performing those services, e.g., where four persons concentrated on staff-development in the past, two persons will carry on this function during the coming year, and (b) concentration on services at the CMHC's will focus primarily on quality improvement over staff expansion needs. The short range goal, then becomes one of emphasizing development of existing

staff, while the long range goal remains one of increasing the mental health workforce (both professional and paraprofessional) to meet more effectively mental health problems in the rural context.

3. Development and Maintenance of an Adequate Supply of Mental Health Personnel

A number of special problems related to manpower development in rural areas have been identified. Some of these problems, each of which can be found in Montana in varying degree, relate to quantity and quality of professional staff; isolation and "burn-out" factors associated with rural living; identification and training of "folk system" providers; adequate support systems to back up mental health workers in sparsely populated areas; access to opportunities for graduate work, undergraduate education, continuing education; and the most effective utilization of paraprofessionals.

Each of these problem areas, among others, were recently confronted in an "Interagency Mental Health Manpower Development Planning Team Meeting" initiated and directed by the Department of Institutions. Key state agency representatives, academic administrators from both four-year institutions of Higher Learning and the three Montana Community Colleges, and a WICHF representative attended this meeting.

The outcome of this two-day meeting resulted in three major accomplishments: (a) problems and issues were identified and prioritized requiring research on basic data needed; (b) four primary goals were articulated; and (c) a standing subcommittee was organized to aggressively pursue these goals and report to the overall team assembled. It is reasonable to expect that more manpower planning, research, and program implementation, involving the joint efforts of the various state departments and the colleges and universities, will be realized than has yet occurred in Montana.

4. Manpower Priorities of the Interagency Mental Health Manpower Development Planning Team Meeting

A. Manpower Resources -

1. Identification of the existing human service needs in Montana and existing manpower in human resources and the services they provide. This resource analysis should appropriately be evaluated across the topological range of communities found in Montana.

a) Natural providers (active and inactive)

b) Local community service programs (public and private)

c) Formal systems (public and private)

(1) Fxternal manpower production

(2) State plans (formal goals and objectives)

Who, what, where, when, how? These are the questions that will be considered in the continuing review of manpower resources in the State.

B. Data Collection - Priority consideration given to the following issues:

1. Who is to be sanctioned to collect data on manpower needs?

2. Who is on the overall planning body (advisory body to data collector)?

3. Resources (funding, staffing) for data collection?

C. Coordination and Communication - Priority given to following problem areas:

1. There is a need for sharing personnel resources and cooperation between governing boards on the local level (mental health, D.D., aging, child care, social services, vocational rehabilitation, public health, Indian Health Service).

2. There is a lack of on-going widely based manpower planning effort, including realistic timelines (state-regional-local).

3. There is a need for expanded information exchange and follow-up (local and state advocacy systems).

D. Education - An extensive listing of problems and priorities were synthesized into the three broad areas of concern below:

1. Definition and delineation: Specific areas in the educational system related to manpower development need to be identified and articulated in a comprehensive state-wide fashion. Issues here would include standardization of content for service providers, continuing education, skill identification and standardized competencies, in-service training, etc..

2. Cooperation and communication: a) Between the educational system and the service delivery system; b) among the various state institutions of higher learning; c) among professions and disciplines involved.

3. Process for change (problems related to implementing changes in the educational system)

5. Interagency Mental Health Manpower Planning Team Statement of Goals

Goal #1

To identify existing human service needs in Montana and the existing manpower resources and services provided.

Goal #2

To develop and coordinate the resources and mount a study in depth from which a manpower development statement of mission and purpose could be extrapolated.

Goal #3

To develop a proposal regarding State manpower needs to present to the Legislative Committee on Human Services.

Goal #4

To develop communication and cooperation between the various educational components throughout the state as they relate to service-providing agencies.

6. Responsibility for Implementation of State Manpower Goals

The direction that mental health manpower development has taken will require the cooperative efforts of various service, administrative and educational systems.

A. Colleges and Universities: The provision of basic education (pre-service training) is a major responsibility to both the professional and paraprofessional provider. The role of Higher Education and curricula content itself is now being reviewed toward provision of required mental health training in professional and para-professional fields as perceived needed in the rural context.

B. Adaptive Services Division - Mental Health Field Services Bureau

Leadership, planning, and overall coordination of the various elements involved in manpower issues is a major responsibility. The Department of Institutions (Adaptive Services Division) has also established goals and objectives as part of this State Mental Health Plan in efforts to upgrade the skill level of mental health manpower. Future efforts should be aimed toward the development of state resources that would build into the service delivery system the necessary capability for continuing education of all mental health professionals and paraprofessionals to ensure effective implementation of program goals and objectives. Special efforts should be made at the state level to provide incentives for the training of Native-American professionals and paraprofessionals to reach more effectively the Indian minority.

C. Community Mental Health Centers: The assurance of continuous and relevant "staff development" is a major responsibility. A diverse range of activities are included in this term such as: formally organized in-service classes, seminars or workshops, case conferences and clinical consultations which are oriented primarily towards an

educational goal, sending staff to attend externally sponsored educational offerings, and the development of organizational policies, structures and resources in the ongoing professional development of agency personnel.

D. Mental Health Practitioners: If the ongoing professional development opportunities are provided in strengthened capacity over time, it still remains for the institutional and community service providers themselves to influence the content and structure of training provisions in ways that is both individually rewarding and congruent with the agency's goals and objectives. The responsibilities of the Universities, the State, and the CMHC Boards, do not diminish the responsibility of each mental health professional to maintain the knowledge and skill in keeping with the standards of each respective profession.

COORDINATION OF PLANNING

Many public and private agencies throughout the State of Montana are involved in the provision of human services. These human service agencies often have functions and responsibilities which overlap or duplicate other human service agency efforts. Because these agencies have separate organization structures and only limited coordination of service planning and delivery mechanisms, the potential for duplicated services, unmet service needs, and inefficient delivery of multiple services to individuals is significant. The Department of Institutions recognizes the need to develop a coordinated approach to services planning and delivery, and is committed to initiating this coordination in the operation of the State Plan for Comprehensive Mental Health Services. This coordination is planned to occur as follows:

Health Planning

It is anticipated that the State Plan for Mental Health will stand as a companion document to the State Plan for Health for a total view of what should be done in Montana in regard to total health services. The present health planning organization within Montana changed October 1, 1976 as per Public Law 93-641. A statewide health coordinating council under the aegis of the Health Systems Agency Board has been established with responsibility for overall health planning. The council works primarily with the Division of Health Planning and Resources Development (Single State Health Authority). To coordinate planning efforts, the Montana Advisory Council for Mental Health and the Mental Health Field Services Bureau are participating with the health coordinating council in evaluation and planning for health and mental health programs.

Identified areas requiring coordination:

- Licensing requirements for community based group homes or alternate living facilities.
- Approval of applications for construction of mental health facilities.
- Coordination of community-based health and mental health programs and personnel.

Further, coordination between State Health and Mental Health agencies and Regional Mental Health programs is enhanced by representation of the Council of Regional Mental Health Boards on the executive committee of the Health Systems Agency Governing Board.

At present, this Plan is consistent with the State Health Plan published in August 1974 under Section 1524(c)(2) of the Public Health Services Act. The State Mental Health Plan will be given to the health coordinating council for review and approval.

Other Human Services

Meetings of several State agencies responsible for human services were held in January and June, 1977. The purpose of the meetings were to initiate coordinated planning among agencies for mental health. Representatives included the Governor's Office, Department of Institutions, Social and Rehabilitation Services (State Title XX Agency), Community Affairs, and Health. Discussion centered on the need for State and local interagency cooperation in planning.

Alcohol and Drugs

Coordination between mental health program planning and alcohol and drug abuse program planning occurs within the Adaptive Services Division (ASD) of the Department of Institutions. As displayed on Exhibit 2, Bureau Chiefs for both programs report directly to the ASD Administrator. Management meetings are held to plan activities, work out solutions to mutual problems and report on progress toward achievement of objectives. As previously discussed, the ASD role in administration of mental health, alcohol and drug abuse programs is primarily monitoring of community based service delivery. Emphasis was placed on Regional Mental Health Boards assuming increased responsibility for administration of broader service programs. As a result, each of the five Regional Boards did review and comment on State Plans for Alcohol and Drug Abuse for Fiscal Year 1977. These Plans were developed into five sections, one for each geographic region, to meet unique regional needs. Specific areas of coordination were:

Alcoholism Services

The Addictive Diseases Bureau amended the State Plan for Alcohol to include the expenditure of all State formula funds through the five Regional Mental Health Boards. Each Board received $40,000 of federal alcohol formula funds for FY '77 which was utilized in the following manner:

-25,000 for all ancillary expenses of a coordinator and developer of alcohol services who provided services to all alcoholics in his region including information and referral. In addition to providing direct services to alcoholics, this regional staff member developed new services where needed in each region and coordinated existing services to avoid duplication and waste of available financial resources.

-$5,000 was utilized for education and training needed to implement the Uniform Detoxification Act.

-$10,000 was utilized for care provided by medical facilities implementing the Uniform Detoxification Act. Payment for services received by alcoholics was made only after documentation and verification of the service was made by the regional coordinator assigned to each of the five regions.

After one year's experience with this project, the plan has been altered by the Addictive Diseases Bureau as there seemed to be uneven success in meeting goals. For the coming year individual regional plans are being developed. Region I will continue with Mental Health Boards' governing role until January 1, 1978 and attempts will be made to develop a regional advisory board. Region II mental health board has divested itself of alcohol responsibility and plans are being forumulated for a new mechanism of coordination within the region. Region III mental health board is no longer responsible for alcohol coordination and plans are in process for an independent coordinating mechanism. In Region IV the mental health board continues to assume responsibilities for alcohol coordination and the alcohol coordinator is an employee of the mental health center. Region V mental health board has been superseded by a Region V alcohol governing board.

At the same time, the Department of Institutions is planning a departmental reorganization which will give alcohol and drugs divisional status.

Drug Abuse Services

Drug abuse treatment activities in the State have not, in the past, been extensively coordinated with Mental Health. At the present time, drug abuse treatment and rehabilitation services are provided by Montana Drug Program and Rimrock Foundation. Drug treatment satellite offices are located in Helena, Butte, Missoula, Anaconda and Bozeman. A therapeutic community, "Lighthouse", is located at Galen State Hospital offering statewide services. Service coordination in these cities has involved local and regional agreements between drug facilities and other service programs, including Comprehensive Mental Health Centers. Agreements with Mental Health Centers have involved reciprocal referral arrangements so that local mental health staff provide psychiatric evaluations of drug abuse clients and drug program staff provide diagnosis of mental health client drug abuse patterns and treatment alternatives.

In other mental health regions, CMHC's provide some drug abuse treatment to a limited number of patients. Services have included outpatient therapy, detoxification, aftercare and follow-up, and chemotherapy. Staff from the drug programs and the Single State Drug Abuse Agency have assisted in these efforts through training programs for representatives of all regional mental health centers.

Community Planning

As stated in the purpose of the Plan, the Department of Institutions aims to provide a mechanism for communication between the Department and other local organizations involved in the delivery of mental health services. Communication is seen as a necessity for responsive and efficient services. No one center, agency or facility can alone provide adequate services to meet the myriad needs of the citizenry. It is necessary to establish a climate of mutual cooperation and understanding in order to obtain comprehensive care. Because of the limited population and large geography of Montana, the Department of Institutions has

decided on the regional approach to provision of services. Regional boundaries selected are identical to the five catchment areas of existing mental health centers. This regional approach is in operation for the five basic mental health services which have been expanded to include alcohol and drug services. Inasmuch as each region has a mental health governing board made up of county commissioners, there is a built-in opportunity for coordination among human services. This is because county commissioners are responsible for a wide variety of local services such as welfare, health, education, corrections, etc.

IV

APPENDIX

APPENDIX A

SURVEY OF MENTAL HEALTH NEEDS AND RESOURCES

OVERVIEW

The purpose of the Mental Health needs and resources survey was to determine relative and potential need for Mental Health programs among the five regional catchment areas. Results indicate that Region I, Eastern Montana, is the region with the highest potential need. The 2nd ranking region is region V. The remaining three regions are ranked #3 as they all have extensive needs and the difference between them is minimal.

The ranking of regions was determined by a statistical analysis of two variables:

-The prevalence of individuals in "high risk" of needing mental health services; and,

-the extent of mental health services presently available within each regional catchment area.

The survey was performed with the best available uniform data to gain a broad perspective of potential needs for new or expanded programs. Results do not indicate the size, number or site-location of new facilities. The state agency is aware of the numerous variables which must be assessed in order to reasonably plan for additional services. Some variables are:

-Availability of required financial and manpower resources.

-Transportation constraints in extremely rural counties.

-Residence of current service population including institutionalized and non-institutionalized patients.

Because Regional Mental Health Boards are the primary organization responsible for planning and implementing additional mental health facilities, survey results are intended to provide guidance in these efforts.

NEEDS SURVEY

The needs survey was conducted to identify "high risk populations" in terms of relative and potential need for mental health services. This determination was based on the prevalence of weighted demographic, social and economic indicators in each regional catchment area. These indicators are known to correlate with admission rates to mental health facilities, and for the most part, provide the best account of variation in small area demographic characteristics. The following lists the socioeconomic and demographic indicators recommended by the Department of Health, Education and Welfare, and briefly describes the reasons for selecting additional social and health indicators.

SOCIOECONOMIC AND DEMOGRAPHIC INDICATORS - 1970 CENSUS STATISTICS

.Percent of males 16 years and over who are in a low occupation status.

.Percent of families below poverty level.

.Youth dependency ratio (i.e. persons under 18 years per 100 persons 18-64 years).

.Aged dependency ratio (i.e. persons 65 and over per 100 persons 18-64 years).

.Percent of household population in housing units with 1.01 or more persons per room.

Draft (2-17-76) Federal Guidelines for the Preparation of State

Plans or Comprehensive Mental Health Services (PL 94-63) - Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health - Division of Mental Health Service Programs.

.Percent of household population who moved into present residence - 1969-1970, i.e. recent movers.

.Indian population as a percent of total catchment area population.

OTHER SOCIAL AND HEALTH INDICATORS

.Marriage dissolution ratio (1974) i.e. number of divorces and annulments per 1,000 persons. This characteristic is generally considered to have an adverse affect on individuals and increases the potential need for mental health services. Further, approximately 4,470 children were affected by some 3,940 marital dissolutions in Montana during 1974. (Source: 1974 Montana Vital Statistics - Bureau of Records and Statistics.)

.Infant mortality ratio (5 year period - 1970-1974) i.e. number of deaths under one year of age per 1,000 live births. This characteristic tends to be highest among the poor and minority segments, and is consistently associated with a large number of stress producing factors. (Source: 1974 Montana Vital Statistics - Bureau of Records and Statistics.)

.Suicide ratio (1974) i.e. number of suicides per 1,000 persons. Although it is recognized that data on suicides can be considerably affected by the way in which deaths are recorded at the local level, this characteristic is considered to be of clinical importance. (Source: 1974 Montana Vital Statistics - Bureau of Records and Vital Statistics.)

.Public Welfare Recipient Ratio (1976) i.e. number of recipients

receiving medical assistance per 1,000 persons. This population is generally highly represented with broken families, handicapped individuals, aged persons, and young children.

Numerical values or all indicators were converted to percentages or ratios to provide a basis or comparison and ranking between catchment areas.

WEIGHTING

As displayed in Exhibits A3 and A4, of the eleven indicators, seven were judged to be of equal clinical importance in determining the relative need for mental health services and assigned a weight of one. The following criteria was used to assign a weight of two to the remaining four indicators:

.Aged and Youth Dependency Ratio, as indicated on Exhibit A4, these characteristics were emphasized due to the current mental health delivery system's deficiency in providing services to these target populations.

.Marriage dissolution ratio - Marriage dissolutions increased by 29% during the period 1970-1974. Further, this characteristic is known to have an adverse affect on children as previously discussed.

.Indian population as a percent of total county population.

RANKING

As displayed in Exhibits A2, A3, and A4, individual rankings for

each indicator were multiplied by the assigned weights and summed to determine final ranking.

RESOURCE SURVEY

The purpose of this survey was to describe and summarize mental health resources in each mental health region and to provide the necessary data for ranking regions in terms of mental health resources. The methodology used to conduct the survey consisted of the following activities:

-Review of available secondary data as follows:

.NIMH Inventory of Comprehensive Community Mental Health Centers (1976).

.Department of Social and Rehabilitative Services (SRS) Adult and Family Services Division - List of Foster Care for Developmentally Disabled, January 1, 1976.

.Department of Social Services and Personnel Services (Payroll) - Warm Springs State Hospital.

.Commission of Higher Education - Psychologists in the State University System.

.Superintendent of Public Instruction, Special Education Program - Psychologists in the State Public School System.

.Bureau of Addictive Diseases - Department of Institutions - Alcohol and Drug Program Resources List.

.State of Montana Board of Psychologists - List of Licensed Psychologists.

.Comprehensive Health Planning Division - Health Manpower in Montana (January 1975).

.State Department of Health and Environmental Sciences - Division of Hospital and Medical Facilities - Licensed Hospitals and Long Term Care Facilities.

-Telephone interviews and,

-Written communication with regional community mental health personnel to augment and verify data collected through review of secondary data.

-Location of present resources;

-type and ownership of facilities;

-number long-term beds for inpatient treatment;

-number of transitional or intermediate beds; and

-estimated total scheduled hours available for mental health services.

Data obtained from these sources were used to:

-Prioritize regions in terms of relative need for mental health services and

-assess present status of mental health delivery as discussed in Section III.

Based on review of results and planning committee discussions the ratio of mental health hours provided per 1,000 population was selected as best representing availability of resources for regional prioritization. Although, recommended in the guidelines (PL 94-63), it was determined that numbers of acute and long term beds would not represent a meaningful indication of available resources due to underutilization of present capacity, and were, therefore, not used to prioritize regions.

WEIGHTING

Assignment of weights to community mental health centers, private, public school and university mental health providers was based on the accessibility of service to residents and specific target groups. As a result higher weights were assigned to community mental health center and public school and university mental health providers as:

-community mental health center services are essentially available for all residents of the state.

-Public school and university systems are available to the youth irrespective of family income,

-while accessiblity of private practioners' services is limited by the ability to pay.

RANKING

As displayed in Exhibits A2, A3, and A4 individual rankings for each indicator were multiplied by the assigned weights and summed to determine final ranking.

PRIORITIZATION OF REGIONS

Final ranking of regional catchment areas based on socioeconomic, demographic, other social and health indicators, and estimated availability of mental health personnel hours is shown in Exhibit A1.

Individual rankings for each indicator were multiplied by the assigned weights and summed to determine regional prioritization.

NOTE: For a more detailed description of the methods used to determine regional prioritization for potential need for mental health services refer to the draft (2-17-76) Federal Guidelines for the Preparation of State Plans for Comprehensive Mental Health Services (PL 94-63) - Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health - Division of Mental Health Programs. Copies of these guidelines are available at the State Department of Institutions, Bureau of Mental Health.

EXHIBIT A-1

	MENTAL HEALTH RESOURCES		OTHER SOCIAL AND HEALTH		SOCIOECONOMIC/ DEMOGRAPHIC		SCORE	FINAL RANKING
	SUMMARY SCORE	RANK	SUMMARY SCORE	RANK	SUMMARY SCORE	RANK		
REGION I	9	1	20	5	20	1	49	1
REGION II	19	5	13	3	26	2	56+	3
REGION III	18	4	11	2	37	4	56+	3
REGION IV	12	2	18	4	38	5	56+	3
REGION V	17	3	9	1	29	3	55	2

See footnotes on the last page of Appendix A

EXHIBIT A-2

RESOURCE SURVEY

ESTIMATED SCHEDULED WEEKLY HOURS PER 1000 POPULATION

REGIONS	COMMUNITY MENTAL HEALTH CENTERS			PRIVATE PRACTITIONERS			UNIVERSITY/ PUBLIC SCHOOL SYSTEM			SUMMARY SCORE	RANK
	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt		
I	7.9	3	2	0.4	1	1	-	1	2	9	1
II	10.4	5	2	1.9	5	1	3.6	2	2	19	5
III	8.6	4	2	1.5	2	1	5.2	4	2	18	4
IV	4.2	1	2	1.8	4	1	3.8	3	2	12	2
V	4.5	2	2	1.7	3	1	6.8	5	2	17	3

See footnotes on the last page of Appendix A.

EXHIBIT A3

NEEDS SURVEY

SOCIAL AND HEALTH INDICATORS

REGIONS	MARRIAGE DISSOLUTIONS			INFANT MORTALITY			SUICIDE			MEDICAL ASSISTANCE RECIPIENTS			SUMMARY SCORE	RANK	SOCIOECONOMIC/ DEMOGRAPHIC SUMMARY SCORE	TOTAL SCORE	RANK
	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt					
I	3.8	5	2	21.2	2	1	0.16	4	1	42.9	4	1	20	5	20	40	3
II	5.3	3	2	17.4	5	1	0.17	1	1	59.7	1	1	13	3	26	39	2
III	5.6	2	2	19.0	3	1	0.17	1	1	44.2	3	1	11	2	37	48	4
IV	4.9	4	2	22.6	1	1	0.16	4	1	41.7	5	1	18	4	38	56	5
V	6.6	1	2	18.9	4	1	0.17	1	1	47.9	2	1	9	1	29	38	1

See footnotes on the last page of Appendix A.

EXHIBIT A4

NEEDS SURVEY

SOCIOECONOMIC AND DEMOGRAPHIC INDICATORS

REGIONS	MALES IN LOW OCCUPATION STATUS			FAMILIES BELOW POVERTY LEVEL			YOUTH DEPENDENCY RATIO			AGED DEPENDENCY RATIO			HOUSEHOLDS WITH 1.01+ PERSONS PER ROOM			RECENT MOVERS (1969-70)			INDIAN POPULATION AS A % OF TOTAL COUNTY POPULATION			SUMMARY SCORE	RANK		
	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt			
I	30.8	5	1	15.1	1	1	76.5	1	2	19.8	1	2	21.7	1	1	23.7	5	1	6.9	2	2	20	1	
II	31.5	3	1	14.1	3	1	74.1	2	2	15.7	5	2	21.1	2	1	28.6	2	1	7.0	1	2	26	2	
III	31.3	4	1	14.3	2	1	67.9	4	2	17.5	4	2	17.1	5	1	25.6	4	1	3.8	3	2	37	4	
IV	35.6	2	1	11.8	5	1	65.5	5	2	19.4	2	2	17.6	4	1	27.2	3	1	0.9	5	2	38	5	
V	38.2	1	1	13.0	4	1	69.6	3	2	17.6	3	2	19.8	3	1	29.0	1	1	2.5	4	2	29	3	

See footnotes on the last page of Appendix A.

FOOTNOTES TO EXHIBITS A 1 TO A 4

NEEDS SURVEY:

SOURCE

.SOCIOECONOMIC AND DEMOGRAPHIC INDICATORS - EXHIBITS A 4

- Percent of males 16 years and over who are in low occupation status (1970)
- Percent of families below poverty level (1970)
- Youth dependency ratio i.e. persons under 18 years per 100 persons 18-64 years (1970)
- Aged dependency ratio i.e. persons 65 and over per 100 persons 18-64 years (1970)

  - U.S. Bureau of Census - 1970 Population and Housing Statistics

- Percent of household population in housing units with 1.01 or more persons per room(1970)
- Percent of household population who moved into present residence 1960-1970, i.e. recent movers (1970)
- Indian population as a percent of total county/region population (1970)

.SOCIAL AND HEALTH INDICATORS EXHIBITS A

- Marriage dissolutions, including divorces and annulments, per 1000 population. (1974)

  - 1974 Montana Vital Statistics - Bureau of Records and Statistics

- Infant mortality ratio i.e. number of deaths under one year of age per 1000 live births (5 years 1970-1974)

  - Bureau of Records and Statistics

- Suicide ratio i.e. number of suicides per 1000 population (1974)

  - 1974 Montana Vital Statistics Bureau of Records and Statistics

- Welfare recipients i.e. recipients receiving medical assistance per 1000 population (1976)

  - Montana Department of Social and Rehabilitative Services

.RESOURCE SURVEY EXHIBIT A 2

- Scheduled hours per 1000 population (May 1976)

  - Community Mental Health Centers

- Estimated scheduled hours per 1000 population (private practitioners) (May 1976)

  - Community Mental Health Centers

- Estimated scheduled hours per 1000 population (1976)

  - Superintendent of Public Instruction and Commission of Higher Education

APPENDIX B

NARRATIVE DESCRIPTION OF CATCHMENT AREAS

OVERVIEW

The development of community mental health services in Montana (population: 694,409 in '70 census) has been episodic in its growth. As an aftermath of World War II, mental hygiene clinics were started in 1948 as an outgrowth of the State Hospital and provided primarily outpatient care. In 1968, the first center was opened in Miles City but it was not until 1972 that the five basic services of inpatient, emergency, day treatment, outpatient and consultation/education were actually in effect in three catchment areas. By 1975 all five regions of the State were federally funded and providing the basic services making Montana the fifth state in the country to offer center services to the total population. However, these operations, minimally funded and having a huge geographic area to cover, were insufficient to appreciably effect the state hospital population. The growing disenchantment in the country to mental institutional care was evidenced in Montana in 1974-1975. A strike at Warm Springs State Hospital and Boulder River School and Hospital led to the National Guard being called in for six weeks and those returning citizens passed the word on the conditions existing in these institutions. The Ministerial Association produced a film "Them & Us" graphically portraying the plight of the institutionalized mentally ill and retarded. On the national level federal judges were taking action through court decisions to liberalize some of the outmoded customs governing the institutions with a strong emphasis on Civil Rights. The 1974 Montana Legislature passed Senate Bill 377 (R.C.M. 1947, Chapter 13), the Commitment Bill, to take effect July, 1975 which was a major step in

restoring civil rights to the institutionalized mentally ill, mandated improvements in care and custody, set up procedures for screening and aftercare and gave greatly increased thrust to community care. A new director of the Department of Institutions was hired in August, 1975 and in December, 1975 a major contract was signed with the five centers and Warm Springs State Hospital whereby funds were diverted from the hospital for greatly expanded screening and aftercare efforts in the community as mandated in R.C.M. 1947, Chapter 13.

The population at Warm Springs State Hospital reached 1,600 at its height in 1961, slowly descended to 903 by July, 1975 and to 480 by June 1, 1977. Obviously, a lot has happened in 1976-1977. The pace has quickened and the demand for community alternatives to institutionalization has increased. However, the mental health centers and the local communities are insufficiently equipped for these new demands. Community alternatives are not extensive and must be adequately developed. As of June 1977 only 14 transitional care facilities for the mentally ill existed in Montana. Sheltered workshops, group homes, foster homes are all in short supply. Community attitudes are untested.

The Department of Institutions sees the regional approach as the logical and most beneficial approach to developing adequate community alternatives. A county or city method of delivery of services would be too diffuse and haphazard. There already exists the nuclei of a regional approach in the existing five mental health centers. However, to expand and increase the scope of these regional centers will be a monumental task, one requiring careful and considerate planning. A large scale increase in community alternatives to institutional care through close cooperation and coordination with existing agencies is required to meet

current goals and objectives.

REGIONAL DEVELOPMENT OF MENTAL HEALTH SERVICES

In 1965 the State Mental Health Program consisted of five mental hygiene clinics which provided limited outpatient services, and Warm Springs State Hospital for residents requiring inpatient psychiatric treatment. These mental hygiene clinics were located in Montana's five largest cities - Billings (Region III), Great Falls (Region II), Butte and Helena (Region IV), and Missoula (Region V).

Legislation was enacted in response to needs identified in Montana's first State Plan for Mental Health Services (June 30, 1965) which resulted in establishing Eastern Montana Regional Community Mental Health Center (Region I) in December 1967. The remaining four comprehensive community mental health centers were established in the following chronological order.

DATE ESTABLISHED	NAME	REGION	NO. OF COUNTIES IN CATCHMENT AREA
January 1, 1971	Western Montana Regional Community Mental Health Center	V	7
September 1, 1971	South Central Montana Regional Mental Health Center	III	11
August 1, 1974	Northcentral Montana Community Mental Health Center	II	9
November 1, 1974	Southwest Montana Regional Community Mental Health Center	IV	12

On August 24, 1971 a Governor's Executive Order established 12 multi-county districts for use in planning and administration. This was amended on October 29, 1973 by Governor's Executive Order 7-73 which directed all state agencies that could most productively serve the state with fewer than 12 districts to adopt the following five administrative regions as displayed in Exhibit A 5.

Region I	Districts 1, 2, and 3
Region II	Districts 4 and 5
Region III	Districts 6 and 7
Region IV	Districts 8, 9, and 12
Region V	Districts 10 and 11

On pp. 36-39 (Section III) there is provided a broad perspective of the State's current mental health delivery system with the extent of population within regions having relative access to existing mental health programs (i.e. population for counties in which facilities for specific services are located divided by the total regional population). As indicated by this section the State currently falls short in meeting state and federal goals and objectives to provide uniform and accessible comprehensive mental health services to all residents, and minimize inappropriate institutionalization. Further, this section provided a basis for prioritizing the relative need for specific services required to meet these goals as follows:

.Transitional services.

.Specialized services for Indians, children and elderly.

.Partial hospitalization.

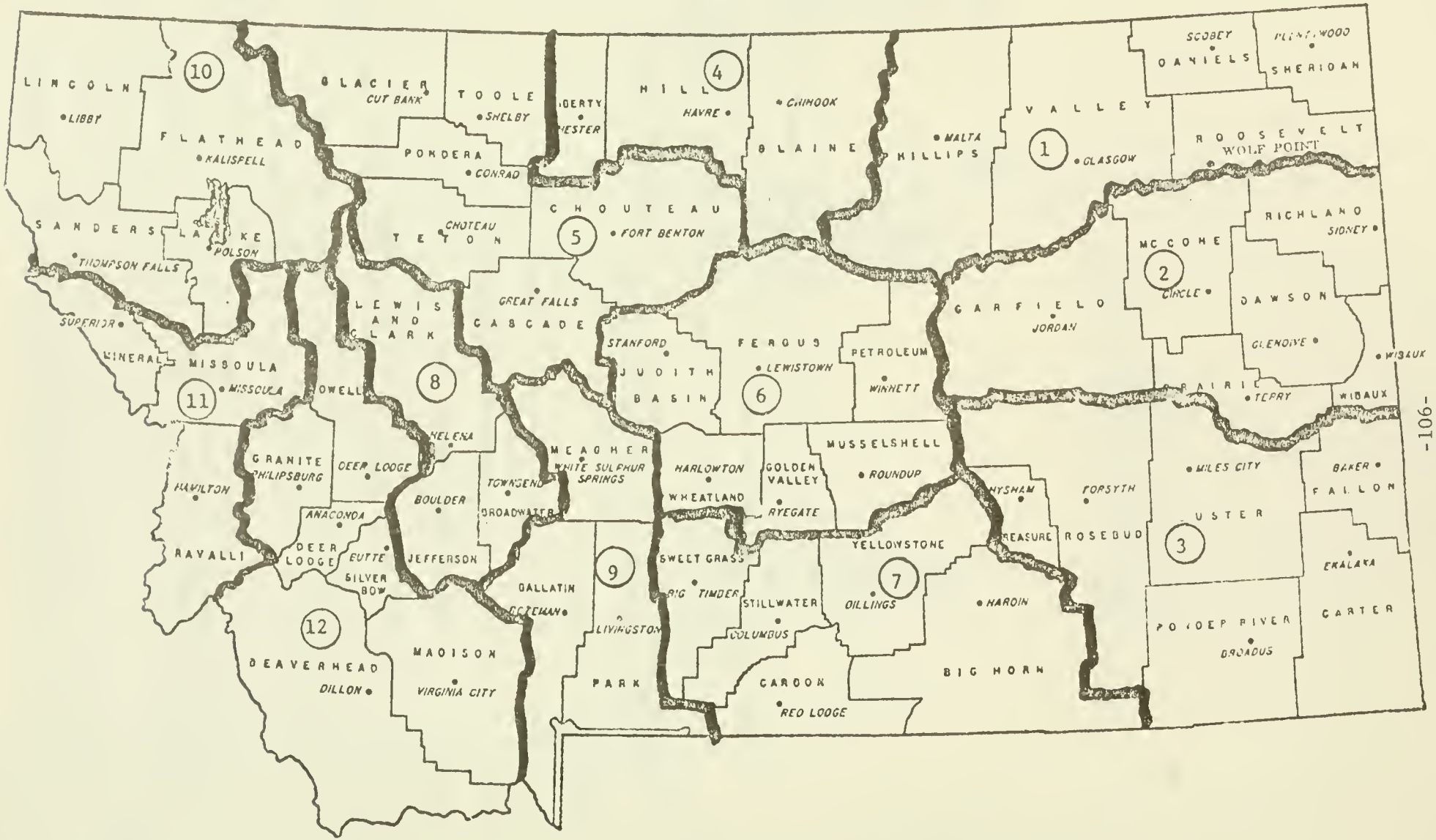
.Specialized services for drug and alcohol abuse.

.Emergency care.

.Outpatient, aftercare, screening and evaluation, and consultation and education.

EXHIBIT A 5

MONTANA MULTI-COUNTY DISTRICTS



No. 1052 — County Outline Map
STATE PUBLISHING COMPANY
Helena

In addition, exhibits are presented below for each catchment area to assist Regional Community Mental Health Boards in planning for additional programs and location of facilities.

For example in Region I, Roosevelt County is ranked as having the highest relative need for mental health services while only six of twelve services are provided in the county.

As displayed in Exhibit A6, Montana's seven Indian reservations are located in the following catchment areas:

Region I - Fort Peck
North Cheyenne

Region II - Rocky Boy
Blackfeet

Region III - Crow

Region V - Flathead

The remaining reservation, Fort Belknap overlaps regional boundaries, portions are located in both Region I and II.

Exhibit A7, delineates the regional boundaries and identifies the location of mental health centers and satellites.

DEMOGRAPHIC

The Eastern Montana Mental Health Region which consists of 17 counties, encompasses one third of the State and lies entirely within the Second U.S. Congressional District. The catchment area is bordered on the north by Canada; on the east by North and South Dakota; on the south by Wyoming; and on the west by Regions II and III.

The program's central facility and administrative headquarters are located in Miles City, Montana's tenth largest city. 1970 population - 9,023 (Source: U.S. Bureau of Census, 1970 Population and Housing Statistics). Exhibit A7 identifies the geographic location of the center's satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)1 TOTAL POPULATION	COUNTIES	(1974 EST.)1 TOTAL POPULATION
Carter	1,900	Prairie	1,900
Custer	12,300	Richland	9,900
Daniels	3,200	Roosevelt	10,500
Dawson	10,900	Rosebud	7,700
Fallon	3,900	Sheridan	5,300
Garfield	1,600	Treasure	1,200
McCone	2,700	Valley	13,000
Phillips	5,500	Wibaux	1,400
Powder River	2,200		
		TOTAL	95,100

1 Source: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The region's catchment area comprises a 47,852 square mile area which is essentially rural and sparsely populated. In addition to overcoming physcial distances to provide mental health services, travel is hampered in the winter months by sub-zero temperatures and heavy snowfalls.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A8 and A9 respectively.

EXHIBIT A-8

AREA MENTAL HEALTH RESOURCES SURVEY

REGION I

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
EASTERN MONTANA REGIONAL MENTAL HEALTH CENTER MILES CITY	PRIVATE NON-PROFIT	1	90 2		348	-	-	-
CENTER SATELLITE ASHLAND	PRIVATE NON-PROFIT				44	-	-	-
CENTER SATELLITE FORSYTH	PRIVATE NON-PROFIT				40	-	-	-
CENTER SATELLITE GLASGOW	PRIVATE NON-PROFIT				160	-	-	-
CENTER SATELLITE PLENTYWOOD	PRIVATE NON-PROFIT				40	-	-	-
CENTER SATELLITE GLENDIVE	PRIVATE NON-PROFIT				80	-	-	-
PHS INDIAN HEALTH CENTER POPLAR	FEDERAL/ OTHER				-	-	-	160 3
PHS INDIAN HEALTH CENTER LAME DEER	FEDERAL/ OTHER				-	-	-	120
PSYCHOLOGIST	PRIVATE PRACTICE				-	36	-	-

1 Generally inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
2 90 beds at Warm Springs State Hospital are assigned to the total Region.
3 Includes a Regional Community Mental Health Center employer - Mental Health Worker.

EXHIBIT A-9

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION I

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
CUSTER	MILES CITY	1	1	2	2	3	2.5	1	1	-	-	2	2	1	0.2	10	8.7
ROSEBUD	ASHLAND	-	-	1	0.1	-	-	1	1	-	-	-	-	-	-	2	1.1
ROSEBUD	FORSYTH	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
VALLEY	GLASGOW	1	1	2	2	-	-	1	1	-	-	-	-	-	-	4	4
SHERIDAN	PLENTYWOOD	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
DAWSON	GLENDIVE	-	-	2	2	-	-	-	-	-	-	-	-	-	-	2	2
ROOSEVELT	POPLAR	-	-	-	-	-	-	-	-	-	-	1*	1*	-	-	1	1
TOTAL		2	2	9	8.1	3	2.5	3	3	-	-	3	3	1	0.2	21	18.8
TOTAL WEEKLY SCHEDULED HOURS		-	80	-	324	-	100	-	120	-	-		120		8		752

* Provides services at the Indian Public Health Service - Fort Peck Reservation.

DEMOGRAPHIC

The Northcentral Montana Mental Health Region consists of a total of nine counties. Of these counties Glacier, Toole, Liberty, and Pondera are within the First U.S. Congressional District, while the remaining five counties fall within the Second or Eastern U.S. Congressional District. Region II is bordered on the north by Canada; to the east by Region I; on the east by Regions III and IV; and to the west by Region V.

The program's central facility and administrative headquarters are located in Great Falls, Montana's second largest city - 1970 population - 60,091 (Source: U.S. Bureau of Census, 1970 Population and Housing Statistics). Exhibit A7 identifies the geographic location of the center's satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Blaine	6,800
Cascade	84,300
Chouteau	6,400
Glacier	11,400
Hill	17,700
Liberty	2,300
Pondera	6,700
Teton	6,400
Toole	5,400
TOTAL	147,400

1 Source: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The region's catchment area is approximately half the size of Region I and comprises 24,082 square miles. While almost 50% of the region's population live in Great Falls and Havre the remainder of the region is rural and sparsely populated.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A10 and A11 respectively.

EXHIBIT A-10

AREA MENTAL HEALTH RESOURCES SURVEY

REGION 11

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
NORTH CENTRAL COMMUNITY MENTAL HEALTH CENTER GREAT FALLS	PRIVATE NON-PROFIT	1	115 [2]		1090	-	-	
CENTER SATELLITE HAVRE	PRIVATE NON-PROFIT				200	-	-	
CENTER SATELLITE CUT BANK	PRIVATE NON-PROFIT				80	-	-	
CENTER SATELLITE SHELBY	PRIVATE NON-PROFIT				80	-	-	
CENTER SATELLITE CONRAD	PRIVATE NON-PROFIT				40	-	-	
CENTER SATELLITE CHOTEAU	PRIVATE NON-PROFIT				40			
PHS INDIAN HOSPITAL BROWNING	FEDERAL/ OTHER							40
PHS INDIAN HOSPITAL HARLEM	FEDERAL/ OTHER							40
PHS INDIAN HEALTH CENTER BOX ELDER	FEDERAL/ OTHER							40
PSYCHIATRISTS (4)	PRIVATE PRACTICE					160 [3]		
PSYCHOLOGISTS (3)	PRIVATE PRACTICE					120		
PSYCHOLOGISTS (13.4)							536	

1 Generally inpatient bed capacity is underutilized - accordingly the beds are available on an as needed basis.
2 115 beds at Warm Springs State Hospital are assigned to the total Region.
3 Includes one Psychologist employed by the U.S. Air Force.

EXHIBIT A-11

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION II

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
CASCADE	GREAT FALLS	-	-	3	3	2	2	8	7.25	7	7	7	7	1	1	28	27.25
HILL	HAVRE	-	-	1	1	-	-	2	2	1	1	-	-	1	1	5	5
GLACIER	CUT BANK	-	-	1	1	-	-	1	1	-	-	-	-	-	-	2	2
TOOLE	SHELBY	-	-	1	1	1	1	-	-	-	-	-	-	-	-	2	2
PONDERA	CONRAD	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
TETON	CHOTEAU	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
TOTAL		-	-	8	8	3	3	11	10.25	8	8	7	7	2	2	39	38.25
TOTAL WEEKLY SCHEDULED HOURS		-	-	-	320		120	-	410		320		280		80		1530

DEMOGRAPHIC

The Southcentral Mental Health Region consists of eleven counties and is entirely within the Second U.S. Congressional District. The catchment area is bordered on the north by Regions I and II; to the east by Region I; the south by the State of Wyoming; and the west by Region IV.

The program's central facility and administrative headquarters are located in Billings, Montana's largest city. Exhibit A7 identifies the geographic location of the center's satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Big Horn	10,500
Carbon	7,900
Fergus	12,900
Golden Valley	900
Judith Basin	2,700
Musselshell	4,200
Petroleum	600
Stillwater	5,200
Sweet Grass	3,100
Wheatland	2,500
Yellowstone	94,300
TOTAL	144,800

1 Sources: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

While approximately 65% of the region's total population are located

in Yellowstone the remaining ten counties are rural and sparsely populated. The region's catchment area comprises a 25,625 square mile area in which agriculture is the dominent industry.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A12 and A13 respectively.

EXHIBIT A-12

AREA MENTAL HEALTH RESOURCES SURVEY

REGION III

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTERS	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
SOUTH CENTRAL MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER BILLINGS	PRIVATE NON-PROFIT	[1]	[2] 115	8	852			
CENTER SATELLITE COLUMBUS	PRIVATE NON-PROFIT				40			
CENTER SATELLITE HARDIN	PRIVATE NON-PROFIT				120			
CENTER SATELLITE RED LODGE	PRIVATE NON-PROFIT				40			
CENTER SATELLITE ROUNDUP	PRIVATE NON-PROFIT				40			
CENTER SATELLITE W. LOWTON	PRIVATE NON-PROFIT				40			
CENTER SATELLITE LEWISTOWN	PRIVATE NON-PROFIT				80			
PSYCHIATRISTS (4)	PRIVATE PRACTICE					160		
PSYCHOLOGISTS (1)	PRIVATE PRACTICE					40		
PSYCHIATRIC SOCIAL WORKER (0.5)	PRIVATE PRACTICE					20		
PSYCHOLOGISTS (16)							640	
MENTAL HEALTH PROFESSIONALS (3)							120	

[1] Generally inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
[2] 115 beds at Warm Springs State Hospital are assigned to the total Region.

EXHIBIT A-13

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION III

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
YELLOW-STONE	BILLINGS	3	0.3	4	4	2	1.5	5	4.5	9	9	1	1	1	1	25	21.3
STILL-WATER	COLUMBUS	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
BIG HORN	HARDIN	-	-	1	1	-	-	1	1	1	1	-	-	-	-	3	3
CARBON	RED LODGE	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
MUSSEL-SHELL	ROUNDUP	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
WHEAT-LAND	HARLOWTON	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
FERGUS	LEWISTOWN	-	-	1	1	1	1	-	-	-	-	-	-	-	-	2	2
TOTAL		3	0.3	10	10	3	2.5	6	5.5	10	10	1	1	1	1	34	30.3
TOTAL WEEKLY SCHEDULED HOURS		-	12	-	400	-	100	-	220		400	-	40	-	40		* 1252

* Includes 1 full-time teacher in the Children's Day Care Program in Yellowstone.

DEMOGRAPHIC

The Southwest Montana Mental Health Region consists of twelve counties and lies within the First U.S. Congressional District. It is the most urbanized of Montana's five mental health regions, and contains four of the state's ten largest cities - Anaconda, Bozeman, Butte and Helena. The catchment area is bordered on the north by Region II; to the east by Region III; south by Yellowstone National Park (Wyoming) and by the State of Idaho; and to the west by Region V and Idaho State.

The program's central facility and administrative headquarters are located in Helena. Exhibit A7 identifies the geographic location of the center's four satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Beaverhead	8,300
Broadwater	2,700
Deer Lodge	15,100
Gallatin	36,000
Granite	2,700
Jefferson	6,900
Lewis and Clark	36,000
Madison	5,900
Meagher	2,100
Park	11,900
Powell	7,400
Silver Bow	43,200
TOTAL	178,200

1 Sources: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The 28,690 square miles of Region IV's catchment area can be described as semi-arid and mountainous. Since counties of the Region lie both to the east and to the west of the Continental Divide, travel is often circuitous. It may be necessary to travel 150 miles to cover an air distance of 25 miles. Mountain passes between Butte and Helena and between Butte and Bozeman make winter travel hazardous. Smaller mountain passes in other parts of the catchment area have similar effects on winter travel which often is completely halted by weather and road conditions.

The urban population of the region is concentrated in Deer Lodge, Gallatin, Lewis and Clark, and Silver Bow Counties. Smelting and mining are the major industries in Deer Lodge County (Anaconda) and Silver Bow County (Butte). Bozeman, in Gallatin County, is the seat of Montana State University and the State Capitol is located at Helena in Lewis and Clark County. The State's only psychiatric hospital is located at Warm Springs in Powell County and other state institutions such as the State Prison, Boulder River School and Hospital, and Galen State Hospital, an Alcoholic Treatment Center are located within the catchment area. The counties of Beaverhead, Broadwater, Granite, Jefferson, Madison, Meagher, Powell, and Park are essentially rural and sparsely populated.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A14 and A15 respectively.

EXHIBIT A-14

AREA MENTAL HEALTH RESOURCES SURVEY

REGION IV

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	Beds			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
SOUTHWEST MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER HELENA	PRIVATE NON-PROFIT	1	2		220			
CENTER SATELLITE BUTTE	PRIVATE NON-PROFIT		242		320			
CENTER SATELLITE ANACONDA	PRIVATE NON-PROFIT				30			
CENTER SATELLITE DILLON	PRIVATE NON-PROFIT				50			
CENTER SATELLITE LIVINGSTON	PRIVATE NON-PROFIT				80			
PSYCHOLOGISTS (8)	PRIVATE PRACTICE					320		
PSYCHIATRIST (1)							40	
PSYCHOLOGISTS (16)							640	

1 Generally inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
2 242 beds at Warm Springs State Hospital are assigned to the total Region.

EXHIBIT A-15

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION IV

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
SILVER BOW	BUTTE	1	1	2	2	2	2	-	-	2	2	1	1	-	-	8	8
LEWIS & CLARK	HELENA	1	1	2	2	2	2	-	-	-	-	-	-	1	0.5	6	5.5
DEER LODGE	ANACONDA	-	-	2	2	-	-	-	-	-	-	-	-	-	-	2	2
BEAVER-HEAD	DILLON	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
PARK	LIVINGSTON	-	-	1	1	1	1	-	-	-	-	-	-	-	-	2	2
TOTAL		2	2	8	8	5	5	-	-	2	2	1	1	1	0.5	19	18.5
TOTAL WEEKLY SCHEDULED HOURS		-	80	-	320	-	200	-	-	-	80	-	40	-	20	-	740

DEMOGRAPHIC

The Western Montana Mental Health Region consists of seven counties and lies within the First U.S. Congressional District. The catchment area is bordered on the north by Canada; to the east by Glacier National Park and portions of Regions II and IV; to the south and west by the State of Idaho.

The program's central facility and administrative headquarters are located in Missoula, Montana's third largest city. Exhibit A7 identifies the geographic location of the Center's five satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Flathead	42,600
Lake	16,700
Lincoln	17,000
Mineral	3,600
Missoula	63,700
Ravalli	17,900
Sanders	7,800
TOTAL	169,300

1 Sources: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The 19,339 square miles of Region V's catchment area lie within the Rocky Mountains. The terrain is rugged, heavily forested, and with numerous basins and valleys, rivers and lakes. The population of the

catchment area is concentrated in the valleys. The University of Montana which has a student enrollment of more than 7,500 is located in Missoula, the largest trade and service center for the catchment area. With the exception of Kalispell in Flathead County all other communities in the region have populations of less than 3,000.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A16 and A17 respectively.

EXHIBIT A-16

AREA MENTAL HEALTH RESOURCES SURVEY

REGION V

NAME AND LOCATION OF FACILITY	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
WESTERN MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER MISSOULA	PRIVATE	[1]	[2]					
	NON-PROFIT		118	4	400			
CENTER SATELLITE KALISPELL	PRIVATE							
	NON-PROFIT				200			
CENTER SATELLITE RONAN	PRIVATE							
	NON-PROFIT				40			
CENTER SATELLITE LIBBY	PRIVATE							
	NON-PROFIT				40			
CENTER SATELLITE THOMPSON FALLS	PRIVATE							
	NON-PROFIT				20			
CENTER SATELLITE HAMILTON	PRIVATE							
	NON-PROFIT				60			
PSYCHIATRISTS (3)	PRIVATE PRACTICE					120		
PSYCHOLOGISTS (4)	PRIVATE PRACTICE					160		
PSYCHIATRISTS (1)							40	
PSYCHOLOGISTS (24.9)							996	
OTHER (2)							80	
PHS INDIAN HEALTH CENTER ST. IGNATIUS	FEDERAL/ OTHER							40

[1] Generally inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
[2] 118 beds at Warm Springs State Hospital are assigned to the total Region.

EXHIBIT A-17

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION V

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
MISSOULA	MISSOULA	1	1	3	3	-	-	3	3	2	1.5	4 *	1.5 *	-	-	13	10
FLATHEAD	KALISPELL	1	1	2	2	-	-	1	1	1	1	-	-	-	-	5	5
LAKE	RONAN	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
LINCOLN	LIBBY	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
SANDERS	THOMPSON FALLS	-	-	-	-	-	-	-	-	1	0.5	-	-	-	-	1	0.5
RAVALLI	HAMILTON	-	-	-	-	-	-	1	1	1	0.5	-	-	-	-	2	1.5
TOTAL		2	2	7	7	-	-	5	5	5	3.5	4	1.5	-	-	23	19
TOTAL WEEKLY SCHEDULED HOURS		-	80	-	280	-	-	-	200	-	140	-	60	-	-	-	760

* Four Doctorate Candidates fulfilling practicum requirements

PROPOSED STANDARDS

FOR

COMMUNITY MENTAL HEALTH CENTERS

STATE OF MONTANA

February, 1977

STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

I. INTRODUCTION

The "Standards for Community Mental Health Centers" March 21, 1974, is hereby rendered obsolete and is replaced by the following Standards:

PREFACE

As the major locus of service delivery in Montana shifts from the single multipurpose state institution to more diversified, locally based and community oriented service components, the state's obligation for coordination, monitoring, and funding becomes increasingly complex. The accompanying Standards serve to reflect both the specific mandates of Federal and Montana State law as well as the more intangible aspects of treatment delivery that we believed to be in concert with the present state-of-the-art.

Development of these Standards was the joint effort of a committee composed of staff from the Mental Health Field Services Bureau, Regional Mental Health Center Board Chairmen or their delegated representative, and Directors from the five Regional Mental Health Centers. Existing standards from the State of Montana as well as community mental health standards from the states of Colorado, Michigan, New York, Utah and Wyoming were reviewed. Where applicable existing standards were found, they were incorporated in the present document. Necessarily, the final authority and responsibility for implementation of the Standards is vested in the Director, Department of Institutions. A permanent study committee has been established under the auspices of the Mental Health Field Services Bureau to periodically review the Standards to insure their continued applicability. Additionally, comments from all concerned parties, including service recipients, will be solicited and where appropriate incorporated in revisions of the Standards. As national standards of performance are developed and are found to be appropriate to Montana's mental health system, accreditation through a national organization would meet the Department's requirements for assurance of a minimum level of performance.

Finally, it is recognized that treatment of the mentally ill is still in the embryonic stage of development and we have not yet achieved a level of sophistication that identifies a single modality as The Way. Consequently, full compliance with the standards as they are presently written is viewed as a goal to be achieved over a reasonable period of time rather than immediate implementation. Thus efforts have been made to allow maximum flexibility to each center in meeting the particular mental health problems indigenous to their community, while concommitantly establishing uniform minimum standards for operation and maintenance.

Legal Authority

The Community Mental Health Center Act of 1963 as amended in 1975, stipulates that those states receiving federal funds for establishment of Comprehensive Mental Health Centers must include in their State Plan of Mental Health Services provision for the establishment and enforcement of Standards of maintenance and operation of community mental health centers:

> "provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title". 1

Responsibility to establish and enforce such standards was delegated to the Department of Institutions by the Montana State Legislature, and are thus promulgated with the full sanction and authority of the legislature.2

The enforcement of community mental health standards can be accomplished most effectively through periodic review of the program. Reviews shall be conducted either separately or jointly by Federal and State consultants including site visits to review the services, records and premises of a center.

The Department of Institutions' authority or his representative shall conduct at least annual reviews of each center program. Additional reviews may be scheduled during the year. Centers found not conforming to the Standards and program plan may be placed on six-month probation period. Should satisfactory progress not be made in the judgment of the Department of Institutions, State funds may be withheld. Center may appeal decision to the Board of Institutions.

[1]Section 237, a(2,E), P.L. 94063

[2]R.C.M. 1947, Chapter 15 80-2802 (8)

ORGANIZATION/OPERATIONS

Under existing Montana law, the Regional Community Mental Health Boards have ultimate responsibility for provision of mental health services within their designated catchment areas. Although generally delegating performance of the day-to-day functions of program implementation, fiscal management and service planning, to be effective the Board must maintain an active and informed role in the overall operations of its center. In fact, the degree to which the Board is involved with the various components of its center's programs will bear directly on the effectiveness of the organization's functioning.

As a legally established corporate body, the Board must comply with and fulfill requirements described in such documents as The Nonprofit Corporation Act, Chapter 28 R.C.M. 1947, and the CMHC STANDARDS. In order to effectively discharge its responsibilities, the Board should establish by-laws and operating procedures which include organizing specific decision-making responsibilities, defining channels of communication, establishing effective committee assignments and other such internal organizational structuring as necessary to optimally discharge its responsibilities.

Because effective decision-making is based on members' respective knowledge of mental health and related fields, the Board should plan and implement an orientation program for its members. Such a program should be an ongoing educational process designed to keep all members informed about the status of its programs as well as new trends in the area of mental health.

The Board should set policies to guide program operations and to protect the rights of its service recipients. It should monitor the implementation and maintenance of these policies to ensure that decisions at the program level are consonant with established Board policies. Finally, to achieve effective long-range planning and to facilitate its program monitoring capabilities, the Board should develop a system of measurable goals and objectives.

1.1 THE ESTABLISHMENT AND ORGANIZATION OF THE BOARD IS CONSISTENT WITH STATE AND FEDERAL REQUIREMENTS

a) The Board is composed of members who are representatives of the residents of their region.

b) The Board shall meet such legal statures as required to receive and administer monies made available through grants from the Federal government, State government, and other agencies, fees for services rendered, tax monies, donations and other types of support or income for purposes of providing mental health services in their region.

c) The Board has established written by-laws.

d) The Board meets regularly, at least 12 times per year (this does not include committee meetings). P.L. 94-63, Sec. 201 C(F)

e) The Board has a defined number of officers and members that comprise quorum attendance.

f) Written minutes which document action taken by the Board are distributed to Board members, all programs affiliated with the Board, and to the County Commissioners of its region following each Board meeting.

g) The Board utilizes a committee structure to conduct the main body of work, and these committees report regularly to the Board.

h) Term of office

i) No conflict of interest

1.2 THE ADMINISTRATIVE ORGANIZATION OF THE BOARD PROMOTES EFFECTIVE OPERATION OF ITS VARIOUS PROGRAMS AND AGENCIES.

a) The Board has an up-to-date organizational chart which accounts for all its services.

b) Decision-making responsibilities within the organization are clearly defined and functioning.

c) Channels of communication within the organization are clearly defined and functioning.

d) The Board has developed an administrative manual that is up-to-date.

e) The Board has clearly defined and measurable short-term and long-term goals and objectives for all its mental health programs.

1.3 THE BOARD DELEGATES TO THE CENTER DIRECTOR RESPONSIBILITY AND AUTHORITY FOR IMPLEMENTATION OF ITS MENTAL HEALTH PROGRAMS.

a) The Board maintains with its Center Director a written contract which specifies the terms and conditions of employment.

b) The Board delegates policy implementation and daily operational functioning to its Center Director.

c) The responsibility and limitations of the Center Director are clearly defined.

d) The Board, through its Center Director, communicates policies to all who need to use them for decision-making.

1.4 THE BOARD HAS PROVISIONS FOR INSURING THE ORGANIZATION AGAINST A RANGE OF LIABILITIES.

The types of insurance a Board carries include the following:

a) Fidelity bonding of key employees (Director, Business Manager, etc.)

b) Professional liability insurance

c) Comprehensive fire and theft insurance

d) Workman's Compensation and/or personal injury insurance

1.5 THE BOARD HAS A PROVISION FOR MONITORING THE DECISIONS AND OPERATION OF ITS PROGRAMS TO ENSURE THAT THEY REMAIN WITHIN POLICY GUIDELINES.

a) The Board receives monthly reports on program operations.

b) The Board receives monthly reports on expenditures.

c) The Board has provision for periodic evaluation of its program relative to program goals.

1.6 THE BOARD PLANS AND IMPLEMENTS AN ORIENTATION AND CONTINUING EDUCATION PROGRAM FOR BOARD MEMBERS.

This program includes information about topics such as:

a) Current concepts of mental health

b) The history and current organization of Community Mental Health in Montana

c) Current methods of program evaluation

d) Confidentiality and clients' rights issues

e) The philosophy and techniques of a comprehensive Community Mental Health model.

f) The responsibility of Board membership

g) Information about sources of funds

h) The Community Mental Health Center Standards

i) The relationship of community mental health to other human services organizations.

1.7 THE BOARD HAS ESTABLISHED ADVISORY COUNCIL(s) TO ADVISE THE GOVERNING BOARD.

a) The Advisory Council(s) shall be representatives of the residents of the region.

b) At least one-half of the members of the Advisory Council(s) shall not be providers of health care.

c) At least one member of the Advisory Council shall be a member of any ethnic or cultural minority group indigenous to the region that comprise 10% or more of the total regional population.

d) Where practical, member of other of other health service agency shall be solicited as Advisory Council members.

e) The Advisory Council should assist the Board with respect to patterns of utilization of sources, impact of services and needs assessment of the regions.

1.8 THE BOARD SEEKS OUT AND NEGOTIATES WITH GOVERNMENTAL AGENCIES AND OTHER POTENTIAL SOURCES OF FUNDS TO SECURE ADDITIONAL RESOURCES NEEDED TO IMPLEMENT THEIR PROGRAMS.

a) The Board has a clearly defined mechanism for seeking funds.

b) The Board is well-informed regarding potential funding sources. They have first hand knowledge (or immediate access to information) about the availability and limitation of funds from potential sources.

c) The Board maintains formal and/or informal contacts with potential funding sources.

d) The Board negotiates adjustments in program proposals when necessary to comply with funding source requests.

1.9 THE BOARD SIGNS WRITTEN CONTRACTUAL AGREEMENTS WITH AGENCIES WHO ARE RECEIVING COMMUNITY MENTAL HEALTH CENTER FUNDS FOR SERVICES PERFORMED. THESE CONTRACTS CLEARLY IDENTIFY THE RESPONSIBILITIES OF BOTH PARTIES.

The contracts should include the following components:

a) A clear description of services to be performed and any limitations or exclusions.

b) The dates during which the contract is binding.

c) The amount of funds to be received by the contract agency and, when feasible, with unit costs or per diem rates.

d) A provision specifying responsibilities of the contract agency to provide the Board with such information as required to evaluate the contract effectiveness.

e) A provision for monitoring of the contract by both parties.

f) A provision which specifies the condition and procedure to be used by either party in terminating the contract.

PROGRAM PLANNING

The basic objective of a Community Mental Health Center Board is to plan and arrange for an array of comprehensive programs designed to ameliorate identified mental health needs. Such need identification should incorporate locally established priorities so that the resulting combination of services is oriented toward the specific and unique requirements of its catchment area. It is also vital that the services of the Center function as components of the larger human services system meeting clients' other needs. To develop such an array of relevant programming and to adequately integrate services in the community requires careful and thorough planning by the Mental Health Center Board.

Such planning is comprised of the following steps: 1) a Statement of Current Needs and Resources; 2) preparation of Program Plans and Budget Requests; 3) the development of services.

A Statement of Current Needs and Resources is based on a detailed assessment of the mental health needs of the catchment area. In addition to identification of specific mental health problems, the statement should also include a description of existing services within the community that address these problems. The statement should describe the mental health services that are needed and summarize those proposed by the Board.

Program Plans and Budget Requests reflect the perceived needs as identified in the Needs Statement and a projection of the financial resource that would be required to implement the proposed services. Each Program Plan should include a description of the need for the particular program, the goals and objectives of the program, the services to be provided, and how the program will be monitored to determine its effectiveness. A Budget Request should accompany each Program Plan and should include a detailed description of the projected costs of the program.

To avoid duplication, the Board must determine if existing services are

adequate or could be expanded to meet identified needs, or if the Mental Health Center should provide the service. If the Board decides to utilize an existing service, both parties must sign an agreement which specifies in detail their mutual responsibilities. If the Board opts to provide the service through the Center, plans must be developed to recruit staff, allocate space, etc.

In Montana, each Comprehensive Community Mental Health Center Board is responsible for planning and implementing programs in at least seven areas: Inpatient Services; Partial Hospitalization; Outpatient Services; Emergency Services; Screening and Evaluation; Aftercare, and Consultation and Education. In addition, the Board is required to develop programs to meet the special needs of the following target populations: children, elderly, alcoholic, drug abusers, and such cultural and/or ethnic minorities that constitute 10% or more of a county's population.

Together, the above categories of services should provide a continuum of services adequate to meet the mental health needs of its catchment area. Certainly, categories of services are not mutually exclusive and clients may be involved in more than one category of service at a given time. Further, clients entering the system at any point may be referred to a more appropriate category of service as his individual needs change with the least restrictive/intensive alternative, generally being the preferred treatment.

Inpatient Services

Programs in this category of services are designed to provide a highly concentrated and structured environment for those individuals who are unable to cope with their emotional crises in a less restrictive environment. The focus of such programs is intensive short-term therapy, geared towards return of the client to his community as rapidly as possible. Generally, release from Inpatient Service is followed by close supervision of the client by Center staff through Partial Hospitalization or Outpatient Services.

Partial Hospitalization

Partial Hospitalization represents a transitional step for patients who no longer require 24 hour care and supervision but who are not yet able to support themselves independently in the community. Programs in this category may be further dichotomized into those providing a variety of treatment programs which aim to change behavior, attitude, skills and the coping ability of clients through specific therapeutic intervention techniques. The second level of programming in this category is programs that are less oriented towards remediation of cognitive and emotional dysfunctioning but are primarily concerned with habilitation and rehabilitation. Such programs might include sheltered workshops, and activity centers. In general, educational activities are emphasized with children, while vocationally oriented activities are emphasized for adult clients.

Outpatient Services

Outpatient Services are mental health services provided clients who are experiencing mental dysfunctioning, but who do not require the intensity of care and supervision of Inpatient or Partial Hospitalization programs. Such services may be provided through a variety of modalities including individual therapy, group therapy, family counseling, home programs, provision of recreational activities and protection of legal and personal rights. Services may be provided at the Center, through outreach, or by home visits by the staff.

Emergency Services

Emergency Services are intended to provide immediate access to mental health services for anyone experiencing an emergent mental health crisis. Such services must include 1) a 24 hour telephone service through which mental health professionals or trained and supervised volunteers may evaluate client-defined emergencies and provide such counseling and referral as they deem necessary and appropriate; 2) provision for backup services appropriate to meet the range of needs presented to the 24 hour crisis telephone service including face-to-face counseling, inpatient hospitalization, and home visit; 3) sufficient public awareness of the emergency telephone number through telephone directory, television and radio advertisement, and dissemination to police and other service agencies.

Screening and Evaluation

As a means of early intervention and avoidance of potential inappropriate institutional referral, screening and evaluation services must be available to clients throughout the catchment area. Additionally, evaluation services should be an integral part of overall client programming and evaluators must work closely with staff of all programs to ensure a coordinated approach to each clients problems. Evaluation staff must also be familiar with State commitment procedures and maintain a close relationship with the courts and legal professions in the region.

Aftercare

Programs in this category are geared primarily towards individuals who are referred to the community from State institutions. The complexity of programs available under aftercare range from the highly structured and supervised environment of a group home to periodic home visits for medication checks or supportive therapy. The general goal of these programs is integration of the client to his maximum potential in the mainstream of community living. As is true of other categories of service, all the resources of the Center are available to the client and such elements of service are incorporated in his treatment program as indicated by his individual needs. Although the goal is fully independent living for each client, it is recognized that many will require long-term or life support from the Center.

Consultation and Education

Although the majority of the mental health professional's time is spent in providing direct services to clients, the indirect services of Consultation and Education is a necessary extension of the Board's programs. Consultation activities can be categorized as client or case centered, and program centered. The former focuses upon the interpersonal relationship between consulters and their clients; the latter deals with problems in planning, developing, managing, evaluating, and coordinating services affecting the community's mental health. The Education component is the dissemination of knowledge related to issues and behaviors which contribute to individual and community mental health. Together Consultation and Education services should be an effective tool of the Board for early intervention and prevention of mental illness.

2.1 EACH COMMUNITY MENTAL HEALTH CENTER BOARD PREPARES AN ANNUAL COMPREHENSIVE SERVICE PLAN WHICH IS UPDATED SEMIANNUALLY AND SUBMITTED TO THE DEPARTMENT OF INSTITUTIONS IN ACCORDANCE WITH DEPARTMENTAL POLICY.

The Comprehensive Service Plan includes the following components:

a) A description of the community to be served including pertinent demographic information, geographic description, economic data, and estimates of the types and extent of significant social and health problems.

b) Estimates of the types and extent of mental health related problems including social indicator data, characteristics of case loads of the Community Mental Health Center, observation of other health service agency case loads.

c) A description of existing services dealing with the estimated mental health-related problems including an evaluation of the degree to which the services match estimated needs.

d) A projection of the amount and type of mental health services needed to adequately serve the comprehensive mental health needs of the client population.

e) A description of how existing and proposed mental health programs fit into the long-range plans described in d above. This should include a priority structure of new programs and estimated dates of implementation.

2.2 THE BOARD SUBMITS TO THE DEPARTMENT OF INSTITUTIONS A WRITTEN PROGRAM PLAN FOR EACH NEWLY PROPOSED AND CONTINUING PROGRAMS IN ACCORDANCE WITH DEPARTMENTAL POLICY.

These plans take into account, and are organized around the following categories:

a) Need/Demand Assessment- This section includes a definition of the specific target problem(s), a definition of the target population, a description of the characteristics of the program case load (for existing programs), and any additional information substantiating the need for the proposed program.

b) Assessment of Existing Community Resources- This section includes an assessment of the nature and extent of the resources of the community with respect to this target problem (e.g. other related services; source of funds, cultural or religious resources of potential clients).

Also included should be a description of the means by which the agency will use existing primary institutions to meet program goals. Primary institutions include schools, families, health and religious agencies which have traditionally been responsible for meeting the needs of people in the community.

c) Statement of Goals and Objectives of the Program- These are time lined statements of the effects to be produced by the programs. They are stated in concrete terms as impacts on the behaviors, skills, attitudes, and situations of the clients to be served. Goals should be precise, understandable, based on the assessed needs and demands of the population to be served (as outlined in a above), and should reflect the assessed community resources (outlined in b above).

d) Description of services to be provided- The Board describes the activities and specific services to be performed in order to achieve the goals and program objectives enumerated above (c).

e) Description of Resources Needed to Implement the Program- This section describes the staff, facilities, materials, etc., which are needed to implement the planned programs.

f) Statement of Means by which the Program will be Evaluated for Effectiveness and Efficiency- This section describes the ways in which the programs will be assessed to determine the extent to which program goals are being met.

g) A Provision which Ensures the Civil Rights of Service Recipients- A person may not be deprived service on the basis of race, nationality, religious or political beliefs, sex, age or ability to pay.

2.3 A BUDGET REQUEST IS SUBMITTED WITH THE PROGRAM PLAN FOR EACH PROGRAM AND INCLUDES A DETAILED BREAKDOWN OF THE PROJECTED COSTS OF THE PROGRAM.

2.4 THE PROGRAM PLAN SUBMITTED BY THE BOARD DESCRIBES A RANGE OF SERVICES WHICH INCLUDE ALL THE TYPES OF PROGRAMS NEEDED TO MEET THE COMPREHENSIVE RESPONSIBILITIES OF THAT BOARD. TO PROVIDE COMPREHENSIVE MENTAL HEALTH SERVICES MEANS TO PLAN SERVICES THAT WILL RESULT IN A CONTINUUM OF CARE FOR ADULTS AND CHILDREN.

The Board should plan programs in at least the following service areas:

a) Emergency services
b) Outpatient services
c) Inpatient services
d) Day program and Activity services
e) Prevention services
f) Aftercare
g) Consultation and Education

Programs should, as appropriate, address each of the following special target populations:

h) elderly
i) children
j) former patients of Warm Springs State Hospital
k) cultural or ethnic minorities indigenous to the region
l) drug and alcohol abusers
m) Transit care

COMMUNITY INVOLVEMENT

For the comprehensive community mental health center concept to become an effective agency of the community, input from all sectors of the community is essential. A basic tenent of the community mental health center movement is that responsibility for a community's mental health problem rests within the community itself. Thus, if the Board is to successfully facilitate the delivery of needed mental health services to the community, it is necessary that the Board involve itself with all levels of the community throughout all phases of program development and implementation.

Further, input and exchange of information between the Board, consumer and citizen groups, other human service agencies and others can greatly enhance a Board's ability to make informed, appropriate decisions regarding programs. Such community participation and input as well as an open receptive attitude towards criticizm regarding development of service can enhance community receptivity to Center service and often prevent serious mistakes.

Public information concerning existing Center programs and proposed changes will also contribute to the general public awareness and utilization of services. Such a program would include not only public speaking engagements, but also use of the public media, distribution of written information, and ensuring that each program funded by the Board is identified as part of Community Mental Health.

3.1 THE COMMUNITY MENTAL HEALTH BOARD PARTICIPATES IN THE PLANNING OF A RANGE OF HEALTH AND SOCIAL SERVICES WITHIN ITS GEOGRAPHIC BOUNDARIES.

a) The Board is aware of and actively involved with regional agencies or councils responsible for health service planning.

b) The Board is actively involved with local school districts.

c) The Board is actively involved with regional interagency coordinating committees.

3.2 THE BOARD HAS PROVISION FOR SOLICITING RECOMMENDATION AND COMMENTS FROM PERTINENT MEMBERS OF THE COMMUNITY REGARDING THE PLANNING AND DEVELOPMENT OF MENTAL HEALTH PROGRAMS.

These include:

a) Provision for making special invitations to interested groups and interested citizens to attend Board meetings or committee meetings.

b) Provision for soliciting input from staff or contract agencies.

c) Provision for soliciting input from groups of people related to or affected by an issue under consideration.

d) Provision for conducting a public hearing on the annual Program Plan and Budget.

3.3 THE BOARD OPERATES AN EFFECTIVE PUBLIC INFORMATION PROGRAM TO FACILITATE AWARENESS OF ITS MENTAL HEALTH PROGRAMS.

a) The Board distributes written information on its mental health services to the community-at-large.

b) The Board uses a range of media for presenting mental health information (newspapers, radio, television, etc.).

c) The Board is available for speaking engagements at various organizations in the community.

3.4 THE BOARD ENSURES THAT ITS PROGRAMS AND CONTRACTED SERVICES ARE VISIBLE AS PART OF COMMUNITY MENTAL HEALTH SERVICES.

a) The board maintains a comprehensive listing of its services in appropriate telephone directories.

b) The Board's public information materials list all programs and services where applicable.

c) Public information materials used by Board programs and contract agencies indicate their affiliation with the Board.

FISCAL MANAGEMENT

A major responsibility of the Board is to ensure accurate and appropriate disbursement of Board funds. In part because the Board is a public non-profit organization supported by public funds, and in part as a result of the complexity of funding source and consequent accounting requirements, it is imparative that the Board adopt clear policies and procedures including written accounting procedures and purchasing policies.

Additionally, public accountability as well as sound fiscal management practices require that the Board provide regular and timely financial reports and perform periodic audits of all accounts.

4.1 THE BOARD ADOPTS CLEAR POLICIES AND PROCEDURES TO ENSURE THE EFFICIENT AND ACCURATE DISTRIBUTION OF FUNDS.

a) There is a Board approved operating budget.

b) Written purchasing policies are followed. These policies require systematic approval by responsible staff for all expenditures for supplies, equipment and contracted service.

c) There is a written procedure for the inventory and control of equipment, etc., costing over $100.00.

4.2 ALL DISBURSEMENTS OF THE BOARD'S FUNDS ARE RECORDED IN SUCH A MANNER AS TO CLEARLY SHOW TO WHICH BUDGET CATEGORY THEY ARE CHARGED.

a) Accounting records clearly show all expenditures.

b) The plan of expenditures corresponds to the current distributinn of staff and other resources.

c) All changes in spending must be consistent with funding source guidelines or be made only with prior written approval from the funding source.

d) Regular and comprehensive financial reports are compiled at least quarterly for the Board and all funding sources.

e) The Board has its financial records audited annually by either public or private auditors.

4.3 THE BOARD HAS CLEARLY DEFINED MECHANISMS FOR THE COLLECTION OF FEES FROM CLIENTS AND THIRD PARTIES.

a) Every client is assessed a fee.

b) The Board adopts a fee schedule that is approved by the Department of Institutions.

c) Adjustments to the collected portion of fees are made according to a client's ability to pay.

d) The Board has procedures for recording all accounts receivable in the general ledger, and a formal procedure for write off of uncollectable accounts.

e) Procedures for billing and fee collection are specified and carried out.

f) Fees are charged to third parties whenever possible.

g) Fees charged and collected by contract agencies are systematically reported to the Board.

PERSONNEL MANAGEMENT

To a very large extent, the overall effectiveness of the Board to provide comprehensive mental health services will be contingent on the quality of its personnel management system. Commensurate with the program size, such a system should be based on comprehensive, written personnel policies and procedures which govern salaries, fringe benefits, hiring and promotional criteria, termination of employment, and define staff responsibilities and limitations. Formal policies should also be established that specify channels of communication between staff and management for mutually satisfactory resolution of employer/employee conflicts. Such policies and procedures should include procedures relating to responsibilities, privileges, and limitations on volunteers, students and interns.

The Board may elect to develop its own personnel management system or it may adopt the State Merit System. Regardless of the method chosen, it should have on file and readily accessible to all employers a complete set of policies and procedures that are consistent with the Community Mental Health Center Standards.

5.1 THE BOARD HAS A COMPREHENSIVE SET OF WRITTEN PERSONNEL POLICIES AND PROCEDURES.

These include:

a) A salary schedule covering all positions

b) Hiring and promotional procedures which are non-discriminating by reason of sex, age, race, irrelevant disability, creed, or marital status.

c) A procedure for suspension and/or dismissal of an employee which includes opportunities for appeal, and requires clear and orderly progress toward such actions with prior warning to the employee.

d) A grievance procedure which allows employees to adequately express their dissatisfaction over employment conditions and assures a fair resolution of expressed problems.

e) Provision for making authorized exceptions to the rules as needed for individual employers.

f) A description of the extent and nature of probation periods for newly hired or promoted staff.

g) Provision to ensure that employees are regularly evaluated by their supervisor as to the degree to which the Center is satisfied with their job performance.

h) Provision for the ongoing review of personal procedures, which include provision for Center staff input.

i) Policies governing an employee's access to his personnel files.

j) Provision for any fringe benefits the Board may provide, such as health insurance, retirement programs, professional liability, insurance, etc.

k) Provision for holiday leave, sick leave, and other types of absences including specific procedures for written requests and written approval of such leaves.

l) Definition of the responsibilities, privileges, and limitations on students, interns, volunteers, and trainees employed at the Center.

m) Definition of the responsibilities and limitations of part-time employees, and employees hired on a contracted basis.

n) A description of Center expectation regarding the ethical behavior of its employees.

o) A description of activities such as outside employment which may cause a conflict of interest, and a description of limitation on employee participation in such activities.

p) Reimbursement procedures for expenses incurred by employees in the line of duty.

5.2 THE BOARD HAS WRITTEN JOB DESCRIPTION AND QUALIFICATIONS FOR EACH STAFF POSITION

a) Job descriptions are derived from program goals.

b) Job descriptions are written in terms of specific tasks and responsibilities of the position.

c) Job qualifications are written in terms of training and experience, and reflect the skills, attitudes and knowledge needed by staff to adequately perform job functions.

d) Job descriptions and qualifications for each position are available to all staff.

5.3 THE BOARD HAS PROVISION FOR ENSURING THAT STAFF POSSESSES THE SKILLS, ATTITUDES AND KNOWLEDGE NEEDED TO PERFORM JOB FUNCTION AT THE TIME THEY ARE HIRED, PROMOTED, OR TRANSFERRED TO A POSITION.

These include:

a) Written procedures for hiring, promoting or transferring staff, including mechanisms for screening and evaluating candidates.

b) A provision to have on file documents which support employee qualifications for their positions, including educational transcripts, licenses, certificates, etc.

5.4 THE BOARD PROVIDES FOR REGULAR EVALUATION OF THE JOB PERFORMANCE OF EACH STAFF PERSON.

a) This evaluation is performed at least twice during an employee's first year, and at least once a year thereafter.

b) Evaluations assess the degree to which each staff person is performing the tasks described in his job description and the degree to which he possesses the skills, knowledge, and attitudes defined by the job qualifications of his position.

c) The factors upon which these evaluations are based are communicated to staff (in writing) at least ninety days before they are evaluated.

d) The results of evaluations are communicated in writing to the evaluated staff person and to supervisors who are involved in staff placement.

PROGRAM ADMINISTRATION

Program administration is divided into four sub-sections: Personnel Management, staff development, interagency coordination, and program evaluation. In general, each subsection addresses the policies and procedures that should be implemented at the individual program level.

Personnel Management

Although section five was also entitled Personnel Management and dealt with the administration function of the Board; this present section deals with the actual implementation of a personnel management system at the program level. Management of the system should be assigned to one or more staff at the center. Job descriptions and qualifications should be maintained for all staff, including physicians, when employed by the Center. There should be a policy to ensure that staff members possess the skills, attitudes and knowledge needed to perform job functions, and provisions for performing regular staff evaluations. Written definitions and procedures for use of all volunteers should be maintained.

Staff Development

The Center should have a written plan for orientation of new staff, continuing education activities and staff development. These activities should be related to specific program goals and may include support of staff attendance at conferences, minority courses, visits to other agencies, use of consultants, joint interagency conferences, or educational presentations within the agency.

Interagency Coordination

Provision of comprehensive mental health services necessitates a close working relationship be established with other State and community human service agencies. The effectiveness of such interagency coordination greatly influences the degree to which continuity of care becomes a functional reality. As a basis

for interagency coordination, the Center must be aware of the specific program goals of other human service agencies, and be provided with current information regarding the types of services offered and any limitation on these services. Similarly, the Center should ensure that other human service agencies receive accurate, up-to-date information regarding the Center's programs.

Program Evaluation

The Center should have the capability to assess the degree to which each of its programs is meeting their established goals and objectives. The Center's evaluation system should provide Center management with such information as necessary to formulate long range planning and budgeting including such quantitative aspects as the Center's caseload, staff utilization and, when feasible, qualitative aspects such as client satisfaction. Although the Center may certainly use information provided through the State, the evaluation program should be designed and implemented to meet the specific informational needs of the Center's management.

Volunteers and Staff Development

6.1 WHEN VOLUNTEERS ARE USED, THE PROGRAM HAS CLEAR WRITTEN DEFINITIONS AND PROCEDURES FOR VOLUNTEERS.

These definitions and procedures include:

a) Procedures and criteria for selecting volunteers.

b) Procedures and criteria for training volunteers.

c) Procedures and criteria for supervising volunteers.

d) A provision for making agreements with volunteers regarding responsibilities (job descriptions) and time commitments.

e) A provision describing the limitations on and privileges of volunteers, including access to files, meetings, etc.

f) A description of the extent to which volunteers may be held liable for their actions at the Center.

g) A description of any reimbursements to be made by the Center.

h) Provisions for malpractice insurance and personal injury or Worker's Compensation insurance.

6.2 THE CENTER PLANS AND IMPLEMENTS A COMPREHENSIVE STAFF DEVELOPMENT PROGRAM

a) The staff development plan is written on an annual basis, and describes the type and frequency of activities.

b) Staff input concerning topic areas is solicited during the initial planning and implementation of the program.

c) Topic areas selected for presentation are related to program goals. When the relationship between the topic area and program goals is not obvious, written justification for those activities should be entered in the plan.

d) Staff development activities occur according to the plan.

e) There are policies and procedures regarding staff attendance at staff development activities.

f) There are procedures for reimbursement of expenses when appropriate.

Interagency Coordination

6.3 THERE ARE ADEQUATE PROVISIONS WHEREBY THE CENTER COORDINATES WITH OTHER HUMAN SERVICE PROGRAMS AND AGENCIES IN THE COMMUNITY TO ENSURE CONTINUITY OF CARE.

a) Staff participate in interagency case conferences.

b) There are written continuity of care agreements between agencies that provide services to the population served.

c) The program has provisions for surveying other community agencies regarding these agencies' degree of satisfaction with its service and interagency coordination. This survey is performed at least annually, and the results are documented.

d) The Center makes efforts to invite pertinent community agencies to appropriate staff development activities.

6.4 THE CENTER HAS PROVISIONS FOR EXPLAINING ITS SERVICES AND PROGRAM GOALS TO ALL PERTINENT AGENCIES AND PROGRAMS IN THE COMMUNITY.

a) The Center distributes current written information on its services to appropriate agencies.

b) The Center meets with (appropriate) agencies at least annually for the purpose of promoting coordination of services.

6.5 THE CENTER MAINTAINS CURRENT WRITTEN INFORMATION ON EVERY OTHER COMMUNITY AGENCY TO WHICH IT MAY REFER CLIENTS.

This information includes:

a) Address and phone number

b) Specific services offered

c) Admission criteria

d) Referral procedure

e) Waiting list

f) Cost of service

Program Evaluation

6.6 THE CENTER HAS PLANNED AND IMPLEMENTED AN EVALUATION SYSTEM WHICH IS ADEQUATE TO DETERMINE THE DEGREE TO WHICH SERVICE ACTIVITIES MEET CURRENT PROGRAM GOALS AND OBJECTIVES.

a) Quantitative characteristics (e.g. caseload information, referral source, staff activities) are systematically monitored.

b) Qualitative characteristics (e.g. measure of client progress, client/family satisfaction) are systematically monitored.

c) Data collection procedures used by the program are minimally disruptive to the operations of the program.

d) The users of the program monitoring system have opportunities to make input into the planning and ongoing refinement of the system.

6.7 EVALUATION REPORTS ARE PRODUCED BY THE PROGRAM AT A FREQUENCY APPROPRIATE TO THE ACTIVITIES BEING MONITORED AND CLEARLY DESCRIBE THE OUTCOME OF THE EVALUATION.

a) Reports are based on data which are current, accurate, and relevant to the goals and objectives being monitored.

b) Data are interpreted and summarized into useful information.

c) Reports include recommendations for remediative action where necessary.

SERVICE DELIVERY:
Policies and Procedures

Service Delivery: The Policies and Procedures of the Service Delivery section is divided into four subsections: Confidentiality, Service Planning and Documentation, Prevention Services and Emergency Services.

Confidentiality

By the very nature of comprehensive mental health and the necessary interagency planning for client service, the Center will frequently be asked to release client information to another human service agency or to the client himself, or may request such information from another agency. Explicit guidelines must be established and adhered to that will provide maximum protection to the clients' right of privacy, while allowing an exchange of essential information between appropriate agency's or personnel. The Center should make it a practice to inform clients of their policies regarding release of client information, indicating the types of information it must share and the conditions under which it must be shared. A sample of each type of release of information form the Center uses (including forms used to release, and to acquire information) should be available and explained to each client for whom a transfer of information is anticipated.

The protection of priviliged information within the Center itself is also important. The Center should have written policies and procedures regarding the security of client records. Also policies should protect client information from indiscrete or indiscrominate discussion among program staff, volunteers, etc.

Service Planning and Documentation

This section addresses those policies and procedures that the Center should implement with respect to case records, including 1) the Center's intake procedure, 2) the procedure used when planning and documenting services, 3) the role and function of the case coordinator and, 4) case record review.

Policies for intake should include a description of each step of the procedure from the initial contact to the actual implementation of services. Where feasible, time frames for completion of major steps should be defined and persons responsible for ensuring that each step is completed should be identified.

Inasmuch as review of case records is a primary means of defining a program's overall effectiveness, adequate policies and procedures for case documentation are especially important. Such policies and procedures should describe a systematic process of service planning, intervention and record maintenance, and should include a description of when and how cases are to be closed. The policies should also describe the duties of case coordinators and how they will be assigned to clients. The basic responsibility of the case coordinator is to ensure that his assigned clients receive all needed human services. The case coordinator may be the client's primary therapist or worker, work supervisor or an individual who is assigned the case coordinator function for the entire Center.

The Center should have policies and procedures which govern three types of record reviews: 1) a review of client's Individual Service Plans performed by the client's therapist or primary worker (see Status Report in Section 9), 2) a qualitative review of the service plan by a committee of peers (Utilization Review), and 3) a review of case records to ensure that they contain all documentation required by agency procedures and the STANDARDS. The latter review may, in fact, be part of the individual or peer review procedures.

The peer review should be performed on an ongoing basis (at least monthly) of a representative sample of Center files. This process should monitor the quality of care being provided to clients, the length of treatment, and the quality of case record maintenance. A report describing the committee's findings, recommendations, any action to be taken, and data for follow-up should be prepared for each record review. Written procedures should describe the methods for selecting committee members, selecting records for review, preparation of committee reports, and the frequency with which the committee will meet. The

record sampling procedures used will dictate how many records are ultimately reviewed, although ideally, every active record should be reviewed at least once during the course of service.

Prevention Services

The Center should address the issue of prevention. Inpatient and Outpatient Services, in particular, should have written procedures to assess the needs of family members of clients. These procedures should include a description of the conditions under which family members will be approached (including client consent), the types of assessments that will be used for child and adult family members, and the steps to be followed when a need is identified.

Emergency Services

Whether it operates or contracts for its Emergency Services program, the Center should ensure that it has a complete set of policies and procedures to govern its operation. These policies and procedures should include a description of staff duties and responsibilities, personnel qualification, how services should be documented, Center limitation and responsibilities, how the system will be tested, and a description of the training program to be used.

Confidentiality

7.1 THE PROGRAM MAINTAINS A COMPLETE SET OF WRITTEN POLICIES AND PROCEDURES WITH RESPECT TO PROTECTING, COMMUNICATING AND ACQUIRING CLIENT INFORMATION.

These include:

a) A description of the conditions under which client information may and may not be released, including a description of the conditions under which written permission for release of information is and is not required from the client.

b) Procedures for securing information about clients from other agencies, and for the subsequent confidentiality of that information.

c) A sample of each type of release of information form used by the program. These forms should specify to whom the information will be released and the conditions or time at which the release form will be effective.

d) A provision that all approved release of information forms will be stored in administration files and a copy of forms will be stored in individual case folders.

e) A provision governing the protection of client information, which ensures the security of records and client information at all time.

f) A provision regarding the length of time that records of terminated clients will be retained and how these records will be destroyed.

g) A provision describing the conditions under which a client may have access to information contained in his case record.

h) A provision that during the intake interview clients will be informed about priviledged communication, including the types of information and the condition under which that information must be released, and to whom it will be released.

Service Planning and Documentation

7.2 THE PROGRAM HAS A COMPLETE, WRITTEN DESCRIPTION OF ITS INTAKE PROCEDURE.

a) Each step of the procedure is defined.

b) Time lines are given for completion of major steps.

c) Staff responsibilities regarding completion of major steps are defined.

d) The intake procedure includes provisions for clients who are experiencing emergencies.

e) There is evidence that the intake procedure has been implemented.

7.3 THE CENTER MAINTAINS A COMPLETE WRITTEN DESCRIPTION OF THE POLICIES AND PROCEDURES ITS STAFF USED IN SERVICE PLANNING, DELIVERY AND DOCUMENTATION.

These policies at a minimum include:

a) A description of the procedures staff will use in service planning which includes provisions for written client assessments, identification of goals, and planning an intervention program.

b) A provision whereby the agency places emphasis on the involvement of the client and on significant others in developing and carrying out service intervention plans.

c) A description of the procedures and time frames for preparing program notes and status reports.

d) A provision which describes when and how cases will be closed.

e) A description of the procedures and time frames for preparing Termination Reports.

f) A description of how the contents of the case record should be organized.

7.4 THE CENTER MAINTAINS POLICIES AND PROCEDURES TO ENSURE EACH CASE IS COORDINATED THROUGH A DESIGNATED INDIVIDUAL.

These include:

a) A provision that a case coordinator shall be assigned to each client, and that the duties of each case coordinator will be described to each client (or responsible adult) by the second service contact.

b) Duties and responsibilities of the case coordinator are specified in writing and include:

1) Coordinating the implementation of the Individual Treatment Plan (ITP).

2) Monitoring the service provided for his clients to ensure that the ITP is followed, reassessed and modified as necessary.

3) Scheduling intra- and interagency conferences on clients as they are needed to coordinate services and to evaluate client progress.

4) Maintaining a current, written record of all mental health and other human services the client is receiving, as well as records of the results of intra- and interagency communication regarding the client.

7.5 THE CENTER MAINTAINS A COMPLETE WRITTEN DESCRIPTION OF THE POLICIES AND PROCEDURES USED TO REVIEW CLIENT CASE RECORDS.

a) Ongoing review to determine whether records contain all the service documentation and release of information documents required by the Center and the CMHC Standards.

b) Periodic review and updating by individual therapists of their client's ITP at a frequency appropriate to the rate and intensity of service (at least quarterly). This may take the form of a Status REport. (Refer to Service Delivery: Case Records: Status Report).

c) Periodic review of records by clinical staff and supervisors (utilization Review).

Prevention Services

7.6 THE CENTER HAS A WRITTEN PLAN COVERING THE STEPS TO BE TAKEN TO ASSESS THE NEEDS OF FAMILY MEMBERS OF CLIENTS WITH DUE REGARD FOR CLINICAL APPROPRIATENESS AND THE CONSENT OF THE CLIENT.

a) Children of adult clients: The Center has procedures for routine assessment of the child's risk status, and the family's needs and the child care capabilities: 1) When a severely disturbed patient or a mentally retarded parent is admitted to services; 2) When inpatient discharge planning is undertaken.

b) Children of adult clients: The Center has procedures to assure that attempts are made to provide stable care arrangements when a primary care given is admitted to inpatient or residential care, or is otherwise unable to meet and fulfill child care needs.

c) Adult family members of adult or child clients: The Center has procedures for meeting the mental health needs of family members.

Emergency Services

7.7 THE EMERGENCY SERVICE SYSTEM OPERATES WITHIN CLEARLY DEFINED GUIDELINES AND PROCEDURES.

These include:

a) A clear description of the duties and responsibilities of the individuals who provide the service (including the steps to be followed in handling emergencies).

b) A description of the qualifications required of the persons who provide the service.

c) A provision to ensure 24-hour telephone service.

d) A description of the procedures to be followed in documenting the delivery of emergency services. These should, at minimum, address identifying information, description of the problem, and action taken.

e) A provision for regular testing and updating on the responsiveness and adequacy of the system such as periodic follow-ups of emergency cases.

f) A provision to ensure that adequate training is provided for all

SERVICE DELIVERY:
Accessibility

The Center's program, including its satellite offices should ensure that their services are readily accessible to actual and potential clients. Such accessibility not only includes how easily a client may acquire services, but also whether he will want to continue to receive services until he no longer needs them. Thus, accessibility is influenced by both physical and social factors.

To the extent possible, the Center and satellite offices should be located near the majority of people in its client population, and should be within walking distance of public transportation routes. Any fees charged should be individualized and commensurate with each client's ability to pay. The program should be able to initiate services immediately in the case of emergencies, and within one week of request in the case of non-emergencies.

As much as possible, the Center should offer services that are tailored to their lifestyle, needs, and characteristics of its clients. Services should be offered at times which are compatible with client's schedules, that is, at times other than regular work or school hours.

SERVICE DELIVERY:
Accessibility

8.1 THE PROGRAM IS LOCATED WITHIN A CONVENIENT DISTANCE FROM POTENTIAL OR ACTUAL CLIENTS.

a) Programs in urban areas are located within thirty minutes driving time of potential and acutal client's homes.

b) Programs in rural areas are located within sixty minutes driving time of potential and actual clients' homes.

c) In areas where public transportation is available, the program is within walking distance from public transportation routes.

8.2 SERVICE FEES SET TO BE COLLECTED FROM CLIENTS CORRESPOND TO THE CLIENTS' ABILITY TO PAY.

a) The Center has a written fee collection schedule that is approved by its governing board and Department of Institutions.

b) The Center has provision for involving clients in the determination of fees.

c) Fees should be equitable throughout catchment area.

8.3 SERVICES TO CLIENTS ARE INITIATED SOON ENOUGH AFTER THEY ARE REQUESTED TO BE MAXIMALLY CURRENT AND USEFUL TO CLIENTS.

a) For clients who are experiencing emergencies, services are initiated with sufficient immediacy to match the urgency of the service request.

b) For clients who are not experiencing emergencies, services are initiated within one week of request. (Initiation of services may be an assessment interview or an intake interview at the beginning of an ongoing service program, and/or a scheduling of a subsequent contact date).

c) There is no evidence of significant service overloads, such as waiting lists.

8.4 THE CENTER OFFERS SERVICES THAT ARE TAILORED TO THE LIFESTYLE, NEEDS, AND CHARACTERISTICS OF THE CLIENTS IT SERVES.

a) The Center offers a range of intervention modalities appropriate to the needs of its service population.

b) The Center offers outreach services.

c) Services are offered to clients at times that are compatible with their schedules so as to be minimally disruptive to other essential functions in their lives (e.g. work, school, child care, public transportation schedules, etc.). When participation by significant

others (family, friends, etc.) is appropriate, allowances should be made for their schedule.

8.5 THE PHYSICAL AND SOCIAL ENVIRONMENTS OF THE CENTER ARE FREE OF ANY FEATURES THAT MAY BE POTENTIALLY OFFENSIVE TO CLIENTS.

a) The facility is free of any obstacles to handicapped clients. That is, the facility has ramps, wide doorways, adequate restroom facilities, etc., for handicapped persons.

b) The Center reports on existing physical barriers and has developed a plan to eliminate these barriers.

c) The Center has developed a plan for delivery of services to clients affected by physical barriers until such barrier can be removed.

d) The Center is free of social barriers to clients. This means the Center's decor and the manner in which its staff interact with clients is both age and/or culturally appropriate to its client population.

e) The physical plant ensures privacy for clients when appropriate. This may include measures for sound-proofing therapy and counseling rooms.

SERVICE DELIVERY:
Case Records

With increasing emphasis being placed on funding and program accountability and the legality of services provided by community mental health agencies, adequate documentation of services becomes of critical importance to each Center's program. Systematic documentation can provide evidence of appropriate use of funds and may protect staff from complaints of violation of rights from service recipients. Additionally, adequate documentation can facilitate continuity of service delivery if a client is transferred to another staff member within the Center, or is transferred to another agency.

Planning and Documenting Services

Organization

Case records should be arranged so that information can be found quickly and easily with current information appearing first. The Center should have written guidelines for case record organization that are used by all staff, so that similar information will be found in the same place from case record to case record.

Client Assessment

Client Assessment, Goals, and the individual Treatment Plan together comprise the components of a systematic approach to service planning. An adequate assessment is the first component upon which the remainder of the system is built.

The STANDARDS describe a full range of factors that should enter into an initial assessment. While all program components of the Center should give consideration to all items, the degree to which any one aspect of assessment would be pursued should depend on the information the program needs in order to provide services. The key to adequate assessment is that it be thorough enough

to determine the mental health and non-mental health related services needed by the client, and at the same time be appropriate to the type of programming he is entering.

For example, the initial assessment performed in an Outpatient setting for a client entering the system for the first time would probably be more extensive than that performed for an Aftercare client. The Outpatient program would need to pursue each aspect of assessment with the client in greater depth than the Aftercare program, which could, to a large extent, rely on input from the client's previous program.

Goals

Once an assessment of client's needs has been completed, treatment goal should be established.

Client treatment goals should reflect at least three major characteristics:

1) Each goal should be derived from the client assessment. Goals could include impacts on the client's resources, such as personal strengths, social and familties and finances.

2) Each goal should be stated in terms of impact on the client. Thus, for each service to be provided, a corresponding statement of anticipated effects on the client should be made. This effect should be stated in terms of specific, observable changes in client behavior, skills, attitudes, etc. Observable changes might include changes in performance on assessment scales or other devices, verbal behavior, attitudes, and so forth.

3) In general, goals should be stated in terms of attaining an improved behavioral or situational state rather than in terms of eliminating negative behaviors.

The goals or statements accompanying them should indicate client participation in this planning and preparation. Where client participation is not appropriate or feasible, a statement explaining such circumstances should accompany the goals.

Each goal should have an estimated time frame for accomplishment.

Individual Treatment Plan

The Individual Treatment Plan (ITP) is the description of services to be provided in order to accomplish the service goals. Each planned service should be described and should clearly derive from service goals.

An I.T.P. should be completed and filled in the client's case record within three weeks of the initial contact with the client. If an extensive assessment is required before goals can be accurately identified, the length of time for filing the plan may be extended but should rarely exceed five weeks from the initial contact.

If the client requires services from one or more other human service agencies, and assisting the client to acquire such services was given as a service goal, then the I.T.P. should indicate how the goal will be met. The plan should briefly state what services are needed, the agency from which the services will be requested, and dates for follow-up contact by center staff to the referred agency.

Program Notes and Status Reports

Once an I.T.P. has been developed, monitoring a client's progress on that plan is essential. Frequent, adequate monitoring of progress allows for determination of the effectiveness of the plan, and may indicate the need for changes in the plan.

The Center should use consistent procedures for preparation of goal-oriented Progress Notes and Status Reports. While standardized forms are often useful as part of these procedures, the critical aspects of monitoring are consistency and the orientation toward the evaluation of client progress toward goals.

Progress Notes: Progress Notes are brief accounts of progress toward goals. Such a note should be prepared at a frequency appropriate to the type of program (see below) and again, may be brief, but should include the following: a description of progress or lack thereof toward the client's service goals; a description of the nature of the service contact; and any other information pertinent to the client's I.T.P. All Progress Notes should be dated and signed.

The frequency of preparing Program Notes will vary with the frequency and intensity of service. Continuous, intense contact with a client would typically require daily notes, while daily contact of a less intense nature would require weekly notes. When contacts are intermittent (i.e. once per week, once per month) a note should be prepared following every contact.

Status Reports: Status Reports are more comprehensive in content and are done less frequently than Program Notes. In essence, a Status Report is a periodic reassessment of the entire I.T.P. and client program. If necessary, it will include an up-dating of the I.T.P.

The Status Report should be prepared by the therapist or primary worker.

The frequency of preparing Status Reports will vary with the frequency and intensity of service. In general, a status report should be prepared after each series of four to eight Program Notes. In NO case should the time between Status Reports be more than six months.

Closing Case

A Termination Report is a report which describes a client's status upon his official termination from a program. While similar to the Status Report, the Termination Report differs slightly in content.

A Termination Report should contain the reason for termination, an evaluation of the impact of agency services on the client's service goals, and any other information relevant to the course of treatment. The Report should include whether or not post-termination programming is planned, either by the Center itself, or through referral to another program in the human services system.

If the Center plans to provide services after termination, for example a follow-up in six months, then these services should be described. If the client will be referred to another program, the Termination Report should contain a listing of recommendations for staff of that program.

Planning and Documenting Services

Organization

9.1 THE CONTENTS OF EACH CASE RECORD ARE ARRANGED IN A UNIFORM MANNER, ACCORDING TO CENTER POLICY, SO THAT INFORMATION CAN BE LOCATED QUICKLY AND EASILY.

Client Information

9.2 A COMPLETE RECORD OF IDENTIFYING INFORMATION IS FOUND IN EACH CASE RECORD.

a) The full name of the client

b) The address and telephone number of the client

c) The marital status of the client

d) The sex of the client

e) The client's date of birth

f) The race of the client

g) The names and addresses of the client's next of kin or legal guardian

h) For all terminated cases, the date of official termination and client status at the time of termination.

i) A case coordinator is identified for each client.

j) Copies of release of information forms are filed in the case record.

Client Assessment

9.3 THE INDIVIDUAL TREATMENT PLAN CONTAINS A COMPLETE, WRITTEN ASSESSMENT OF CLIENT NEEDS AND STRENGTHS THAT IS SUITABLE TO THE TYPE OF PROGRAM.

a) A description and evaluation of the presenting problem.

b) A diagnostic formulation, including clinical evidence which supports the formulation.

c) A summary of input from the client regarding his evaluation of the problem.

d) A summary of input from family, friends or others where appropriate.

e) Summaries of input from pertinent service agents with whom the client was involved.

f) A statement of client strengths and other resources that may contribute to the course of treatment.

g) A statement indicating that physical health and other possible human service needs were considered. Any such identified needs are listed.

h) A listing of medications currently used by the client.

i) Summaries of the results of psychological or other tests used during the assessment.

j) A summary of observations of the client by the primary therapist or worker.

Service Goals

9.4 THE INDIVIDUAL TREATMENT PLAN CONTAINS A COMPLETE SET OF CLEARLY STATED SERVICE GOALS THAT ARE DERIVED FROM THE INITIAL ASSESSMENT.

a) Each service goal is clearly derived from the initial assessment of client needs and strengths.

b) Each service goal is stated in terms of specific, observable changes in behavior, skills, attitudes or circumstances.

c) Each service goal is described in terms of attaining a more satisfactory state with the client rather than simply eliminating negative behaviors.

d) There is evidence that client input was considered in identifying service goals. If goals will result in major changes in lifestyle, there is evidence that such changes were mutually planned by the client and the staff member.

e) A time frame for attainment is given for each goal.

Individual Treatment Plan

9.5 THE INDIVIDUAL TREATMENT PLAN CONTAINS A WRITTEN INTERVENTION PLAN WHICH DESCRIBES THE RANGE OF SERVICES THAT WILL BE PROVIDED IN ORDER TO ATTAIN SERVICE GOALS.

a) There is a description of each service to be provided.

b) Services are derived from established service goals.

c) If the Center does not offer needed human services, referrals to the appropriate agencies are indicated. A copy of the written description of the client's service needs and service request that was submitted by the Center, and dates and results of follow-up contacts by the Center are entered into the record.

d) The Treatment Plan indicates how the client will be actively involved in his own problem solving.

e) The written Treatment Plan is filed in the client's case record within three weeks after the first client contact. If a lengthy assessment period is needed, the Plan is filed within five weeks of the first contact.

f) A date upon which the initial Treatment Plan will be reviewed and modified is indicated.

Progress Notes

9.6 COMPLETE PROGRESS NOTES ARE FILED IN THE CASE RECORD.

These notes include:

a) The date of contact

b) The approximate duration of the contact

c) The name(s) of the client(s) involved.

d) A brief description summary of the nature of the service contact.

e) A brief descriptive statement of significant client progress, or lack thereof, towards service goals.

f) Each progress note is signed and dated by the individual who prepared it.

9.7 PROGRESS NOTES ARE FILED AT A FREQUENCY APPROPRIATE TO THE TYPE OF PROGRAM.

Inpatient Services	Daily
Partial Hospitalization	Weekly
Transitional Residential Services	Weekly
Outpatient Services	Within 24 hours of every client contact
Prevention Services	Appropriate to frequency of contact.

Status Reports

9.8 COMPLETE STATUS REPORTS ARE FILED IN THE CASE RECORD.

These reports include:

a) A description of client progress, or each thereof, with respect to each service goal.

b) A description of any changes in the assessment of the client's needs and/or resources.

c) A description of any changes in the Treatment Plan that results from changes in the assessment, service goals, or other factors.

d) A listing of the sources of information on which the status report was based, including specific people.

e) A statement describing the client's degree of satisfaction with his course of treatment at the Center. If he is not satisfied, the report shows justification for the situation, or present a plan for modification of the course of treatment.

f) The signature of the case coordinator or individual responsible for preparing the report, and the date of preparation.

Closing Cases

9.9 TERMINATION REPORTS ARE FILED IN THE CASE RECORD.

They include:

a) A reason for termination

b) A summary description of the services provided by the Center including referrals to other agencies, and follow-ups to such referrals.

c) An evaluation of the impact of the Center's services or each of the client's service goals.

d) A statement of the client's apparent satisfaction with his course of treatment at the Center.

e) A statement as to whether or not post-termination programming is needed. (Records on clients who require further programming should include f below).

f) Recommendations or other information for those who will be involved in the client's post-termination program, and description of follow-up contacts planned by the Center.

g) The signature of the staff member who prepared the report and date of preparation.

9.10 TERMINATION REPORTS ARE FILED IN CASE RECORDS AT THE APPROPRIATE TIME.

a) For self-terminated clients, and center-terminated clients who will not require further programming after termination, and clients who are served in one contact only, a termination report should be filed in the case record within two weeks after official, written termination of services.

b) For Center-terminated clients who will be referred to other agencies, a termination report is filed in the case record prior to completion of the referral.

Emergency Services

9.11 THE EMERGENCY SERVICE SYSTEM MAINTIANS COMPLETE RECORDS FOR EACH CLIENT IT SERVES.

These records should include:

a) Identifying information to the extent it can be obtained.

b) The date and time of contact.

c) A description of the nature of the emergency.

d) A description of any action taken, including referrals, necessary follow-up, etc.

e) The signature of the person(s) who prepared the report.

Record Review

9.12 THERE IS EVIDENCE IN THE CASE RECORD THAT RECORD REVIEW PROCEDURES HAVE BEEN IMPLEMENTED.

These procedures include:

a) Ongoing review to ensure the record contains all necessary information.

b) Periodic review of the Individual Treatment Plan by the case coordinator or individual therapist.

c) Periodic review of the Individual Treatment Plan by a committee of peers (Utilization Review).

In addition to the federal regulations, standards encompass state requirements mandated in House Bill 289, Senate Bill 377, and Senate Bill 388. The following briefly summarizes the state laws and regulations.

House Bill 289, Appropriations Act

- .. total proposed and historic costs of center
- .. number of clients to be served
- .. provision that available non-general funds be spent prior to the use of general funds
- .. nature and levels of service to be rendered
- .. measurable performance indicators

Senate Bill 377, Treatment of Mentally Ill Act (Chapter 13 of Title 38, R.C.M. 1947)

- .. voluntary admission to the Montana State Hospital
  - . certification from the respective regional mental health center director or, if not reasonably available, from a professional person that the applicant is suffering from mental disorder and that local facilities are unable to provide adequate evaluation and treatment
  - . facility has right to detain applicant for no more than five (5) days past a written request for release

.. involuntary admission to the Montana State Hospital

. upon receipt of petition alleging person as seriously mentally ill, a professional person shall examine the person--the examination cannot exceed four (4) hours

. on the basis of the evaluation, the professional person shall recommend in writing either that the petition be dismissed or that a seventy-two (72) hour inpatient evaluation and treatment be ordered

.. Emergency Situation

. any person who appears to be seriously mentally ill can be taken into custody and a center professional person should be notified

. if the professional person concurs that an emergency situation exists, the person can be detained until the next regular business day when the professional can file a report and/or petition

. when petition is filed, the person can be detained for twenty-four (24) hours so that the professional person can conduct the examination (do not count Saturday, Sunday, or legal holidays)

. if the professional person so recommends and, contingent upon a hearing (unless waived by the respondent), the court may order the person to be detained for a seventy-two (72) hour evaluation and treatment period

. whenever possible, a peroon shall be detained in a mental health facility

. medication shall not be used as a punishment, for the convenience of that staff, as a sub-stitute for a treatme that interfere with the patient's treatment program

.. Professional Person - qualifications for admitting persons to mental health facility

. shall meet all certification requirements promulgated by the Department of Institutions

.. Treatment Plan

. each person admitted to a mental health facility for more than seventy-two (72) hours shall have a comprehensive physical and mental examination and an individualized treatment plan developed by appropriate professional persons, including a psychiatrist if reasonably available, and implemented no later than five (5) days after admission

.. Follow-up

. an affirmative duty to provide adequate transitional treatment and care for all patients released from a mental health facility after a period of involuntary confinement

.. Client Records

.. Confidentiality

Senate Bill 388

This is an Act to provide for the identification, habilitation and human rights of the developmentally disabled. Compliance is similar to Senate Bill 377.

Senate Bill 378, Governing Formulation of Comprehensive Mental Health Centers, (Chapter 12 of Title 38, R.C.M. 1947)

.. Departmental (Department of Institutions) contracts with mental health corporations

. prevention, diagnosis and treatment of the mentally ill

. can by provided for directly by state agencies or indirectly through contract or cooperative arrangements with other agencies of government, regional or local, private or public, private professional persons or hospitals, under rules adopted by the Department

.. State funds specifically appropriated for regional mental health service shall not exceed fifty percent (50%) of the budget approved by the Department of Institutions. Warm Springs State Hospital funds may be transferred to regional mental health centers for WSSH patients returned to the community.

.. Nonprofit Corporations

. regionalization

. regional mental health board comprised of county commissioners of the various counties in the region or a person designated by the commissioners to represent the county on the regional corporation board

.. The board of mental health shall submit an annual budget prior to June 10 of each year, to the board of county commissioners of each of the counties within the region, which specifies each participating county's proportionate share of the budget

APPENDIX D

PERCENT OF POPULATION BELOW POVERTY LEVEL

REGION I

Carter	17.5	Prairie	19.1
Custer	11.6	Richland	13.8
Daniels	10.1	Roosevelt	23.3
Dawson	8.4	Rosebud	25.8
Fallon	12.6	Sheridan	11.4
Garfield	17.3	Treasure	22.8
McCone	13.8	Valley	16.8
Phillips	16.6	Wibaux	15.2
Powder River	13.0		
		Regional	15.1

REGION II

Blaine	31.4	Liberty	8.4
Cascade	10.9	Pondera	18.2
Chouteau	11.6	Teton	12.0
Glacier	29.5	Toole	11.6
Hill	14.8		
		Regional	14.1

REGION III

Big Horn	25.3	Petroleum	17.8
Carbon	19.2	Stillwater	13.7
Fergus	14.9	Sweetgrass	23.6
Golden Valley	11.7	Wheatland	16.3
Judith Basin	15.2	Yellowstone	12.1
Musselshell	19.2		
		Regional	14.3

REGION IV

Beaverhead	17.4	Lewis & Clark	8.8
Broadwater	23.1	Madison	18.1
Deer Lodge	10.8	Meagher	24.9
Gallatin	11.1	Park	14.3
Granite	15.8	Powell	9.5
Jefferson	13.4	Silver Bow	11.4
		Regional	11.8

REGION V

Flathead	12.9	Missoula	11.2
Lake	22.3	Ravalli	18.6
Lincoln	7.1	Sanders	14.0
Mineral	8.4		
		Regional	13.0

Region I has been designated by National Institute of Mental Health as meeting poverty classification status in Montana. Additionally, Region III has been found to meet the statistical requirements for designation as a poverty area.

V

A T T A C H M E N T S

APR 1 0 1976

State of Montana
Office of The Governor
Helena 59601

Attachment 1

THOMAS L. JUDGE
GOVERNOR

April 13, 1976

Dr. Robert Mattson, Director
Department of Institutions
1539 11th Avenue
Helena, Montana 59601

Dear Bob:

In accordance with P.L. 94-63, the new Comprehensive Mental Health Act, I am designating your department as the single state agency for preparation of both the Mental Health Construction Plan and the Comprehensive Mental Health Plan for the State of Montana.

I look forward to receiving your recommendations for persons to serve on the Mental Health Advisory Council which will be reviewing the Mental Health Plan this spring.

Since the Department of Health and Environmental Sciences is designated as the department to prepare the State Health Plan and to do specific plan reviews and approvals, I expect that you will need to coordinate closely your work with theirs. If there is any way in which my office can be of assistance, please let me know.

Best regards.

Sincerely,

Tom

THOMAS L. JUDGE
Governor

cc: Dr. A. C. Knight
Dr. Stanley Mahoney

RECEIVED
APR 1 0 1976
DEPARTMENT OF INSTITUTIONS

Attachment 2

STATE OF MONTANA

DEPARTMENT OF ADMINISTRATION

MERIT SYSTEM COUNCIL
CAPITOL STATION
HELENA 59601

OCT 28 19

October 27, 1976

Mr. Phil Powers, Chief
Mental Health Bureau
Capitol Station
Helena, MT 59601

Dear Mr. Powers:

The Montana State Merit System Rules and Regulations have been developed in accordance with the Federal Standards for a Merit System of Personnel Administration. The Federal Standards promulgated and adopted by the Department of Labor, Department of Health, Education and Welfare, and the Department of Defense, are listed as Code of Federal Regulations 45, Part 70, Subparentheses (1), (2), (3), etc. Our rules and regulations, in addition to being approved by Merit System agencies and Merit System Council, must be approved by the U.S. Civil Service Commission and the agencies which have signed off on the federal code.

I can assure you our rules and regulations are in compliance with the Code of Federal Regulations regarding the standards for a Merit System of personnel administration.

Sincerely yours,

Clifford T. McGillvray
Administrator
Merit System Council

Enclosure
Merit System Rules

CTM/bh

AN EQUAL OPPORTUNITY EMPLOYER

ATTACHMENT 3

State of Montana

Department of Institutions

GOVERNOR
THOMAS L. JUDGE

DIRECTOR
ROBERT H. MATTSON

BOARD MEMBERS
ZELLA A. JACOBSON GREAT FALLS
ELDON E. KUHNS, BILLINGS
WILLIS M. McKEON MALTA
ROBERT J. PALLO, KALISPELL
JOHN W. STRIZICH M.D., HELENA

Helena, 59601

November 1, 1976

Larry Carlson, Administrator
Adaptive Services Division
Department of Institutions
Helena, Montana 59601

Re: Mental Health Council's Compliance with Non-Discrimination

Dear Dr. Carlson:

After examining the current law in Montana, it is my opinion that the several mental health corporations which we contract with to provide mental health services must comply with both federal and state law concerning non-discrimination as far as services and employment.

Under federal law, Title 6 of the 1964 Civil Rights Act and 42 USE, Section 2000D, agencies receiving federal funds must be in complete compliance with non-discrimination policies. Further, the 1972 Montana Constitution and Title 69 of the Revised Codes of Montana, 1947, insures that there is no discrimination in Montana. To do so, would be a clear violation of both federal and state law. I feel that our contracts with the mental health centers guarantee that there is compliance to both federal and state law as to non-discrimination.

Also, Montana law, 59-501, R.C.M. 1947, assures that members of the board of directors of mental health corporations are not involved in conflicts of interest as members. I view this as compliance with accepted standards.

Very truly yours,

Nick A. Rotering

Nick A. Rotering
Special Assistant Attorney General
for the Department of Institutions

NAR/clk

Attachment 4

MAY 17 1976

Department of Health and Environmental Sciences
STATE OF MONTANA HELENA, MONTANA 59601

May 17, 1976

A.C. Knight, M.D., F.C.C.P.
Acting Director

Dr. Laurence Carlson, Administrator
Adaptive Services Division
Department of Institutions
Helena, Montana 59601

Dear Dr. Carlson:

At the request of Mr. Larry Gustafson, I am sending you the estimated cost of administering the Mental Health Construction plan in FY 1968. None of the allowable percentage of the grant was spent for administration so the figure shown represents state money.

Number of people involved: 1 professional, 1 clerical
What percent of bureau time spent: approximately 5%
Total estimated dollar cost: $2000

Sincerely,

Wallace A. King, Chief
Resource Development Bureau
Division of Health Planning & Resource Development

WAK/CA/g

Attachment 5

State of Montana
Office of The Governor
Helena 59601

THOMAS L. JUDGE
GOVERNOR

MEMORANDUM July 31, 1973

To: All State Agencies

From: Thomas L. Judge, Governor

Re: Multi-County Districting

On August 24, 1971, my predecessor, Governor Anderson, created twelve multi-county districts in order to enhance state agency administration and state planning coordination. Implementation of that order has, in some instances, been delayed due to district and Supreme Court action on challenges to the districting system. On March 28, 1973, the Supreme Court upheld Executive Order 2-71 and removed all legal barriers to its full implementation. A review and evaluation of the multi-county districting system conducted last fall indicated no substantive difficulties among those agencies which had proceeded to implement the uniform districting system. It was found that the activities of some state agencies were more appropriately conducted within groupings of districts rather than on a single district basis. A particular pattern of district groupings occurred most frequently and is shown on the enclosed map.

Based on the above court rulings and evaluation, I am proceeding to fully implement the multi-county districting system created in Executive Order 2-71. In addition, I am directing those agencies that can most productively serve the state with fewer than twelve districts to adopt five administrative regions composed as follows:

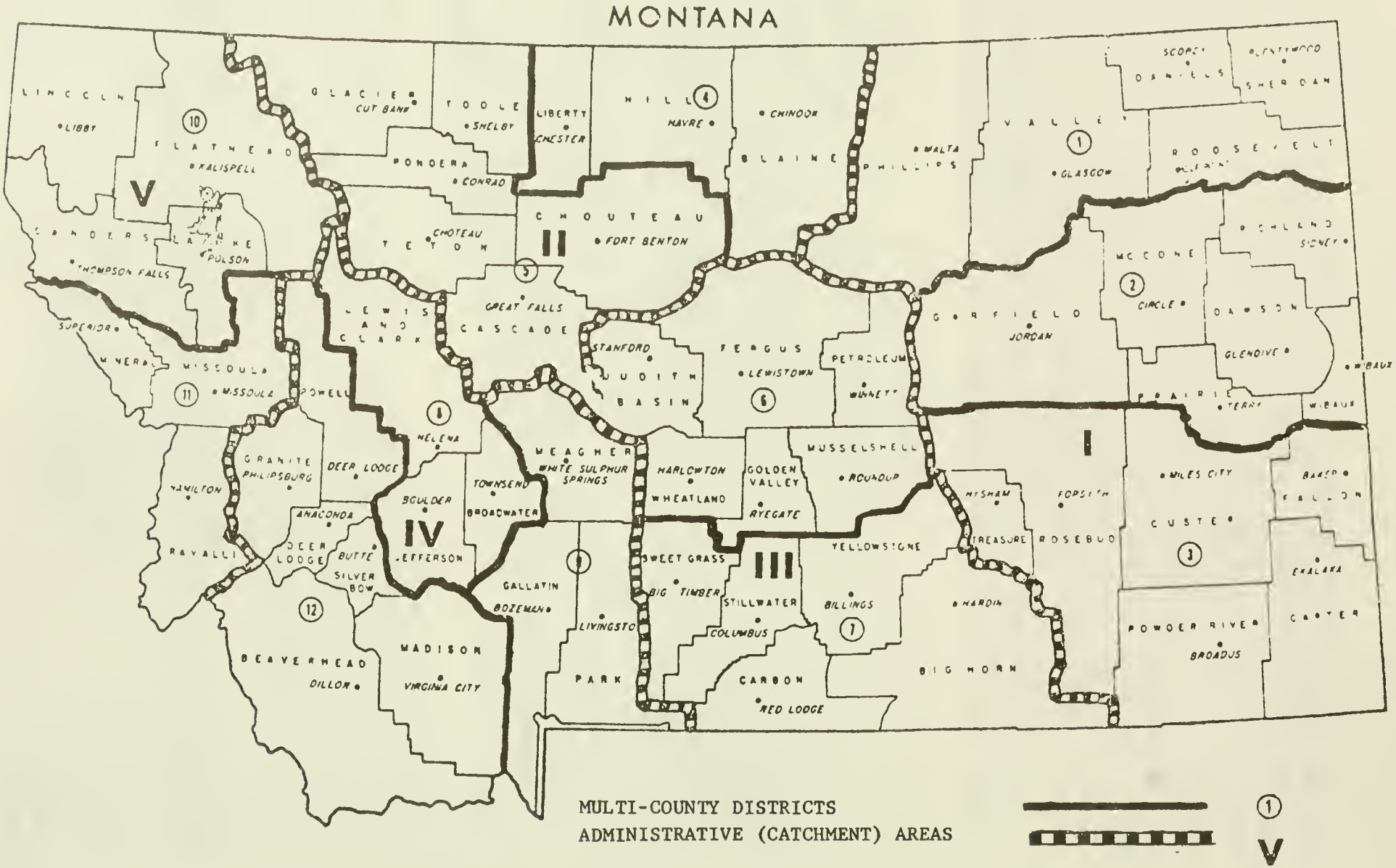
Region I - Districts 1, 2, and 3
Region II - Districts 4 and 5
Region III - Districts 6 and 7
Region IV - Districts 8, 9 and 12
Region V - Districts 10 and 11

One of the objectives of Executive Order 2-71 was to facilitate planning and program coordination, administration, and delivery

of services by all levels of government within the State." In order to involve local governments as full partners in the district decision-making process, the Department of Intergovernmental Relations has developed guidelines for local governments to follow in establishing district councils. These councils will provide a vehicle for state agencies to communicate with local government. More important, these district councils will develop statements of district policy that will assist in the development of state agency plans and programs. The Department of Intergovernmental Relations will be assisting local governments in the formation of district councils and will be responsible for state recognition of qualified Councils. Information on the relationship between state agencies and district councils and the roles of each will be forthcoming in the near future.

I am asking each department to describe its present districting or arrangements and plans for compliance with the designated districts on the attached form. These should be returned to Dorothy Eck, State-Local Coordinator, Department of Intergovernmental Relations.

Enclosures (2)


MONTANA
LINCOLN
LIBBY
FLATHEAD
KALISPELL
V
GLACIER
CUT BANK
TOOLE
SHELBY
LIBERTY
CHESTER
HILL
HAVRE
CHINOOK
BLAINE
PHILLIPS
MALTA
VALLEY
GLASGOW
SCOBEY
DANIELS
SHERIDAN
ROOSEVELT
PONDERA
CONRAD
CHOUTEAU
FORT BENTON
II
TETON
SANDERS
LAKE
POLSON
THOMPSON FALLS
MCCONE
CIRCLE
RICHLAND
SIDNEY
DAWSON
GLENDIVE
GARFIELD
JORDAN
PRAIRIE
TERRY
WIBAUX
LEWIS AND CLARK
GREAT FALLS
CASCADE
STANFORD
JUDITH BASIN
FERGUS
LEWISTOWN
PETROLEUM
WINNETT
SUPERIOR
MINERAL
MISSOULA
11
MISSOULA
POWELL
4
HELENA
GRANITE
PHILIPSBURG
DEER LODGE
MEAGHER
WHITE SULPHUR SPRINGS
HARLOWTON
WHEATLAND
GOLDEN VALLEY
RYEGATE
MUSSELSHELL
ROUNDUP
I
MILES CITY
CUSTER
3
FORSYTH
MYSHAM
TREASURE
ROSEBUD
BAKER
FALLON
HAMILTON
RAVALLI
ANACONDA
DEER LODGE
BUTTE
SILVER BOW
BOULDER
IV
JEFFERSON
TOWNSEND
BROADWATER
GALLATIN
BOZEMAN
1
SWEET GRASS
BIG TIMBER
III
STILLWATER
COLUMBUS
YELLOWSTONE
BILLINGS
7
HARDIN
BIG HORN
POWDER RIVER
BROADUS
CARTER
EKALAKA
12
BEAVERHEAD
DILLON
MADISON
VIRGINIA CITY
PARK
LIVINGSTON
CARBON
RED LODGE
MULTI-COUNTY DISTRICTS
ADMINISTRATIVE (CATCHMENT) AREAS
1
V

STATE OF MONTANA
Conversion Grant Rankings
Community Mental Health Centers

For purposes of the Conversion Grants to the mental health centers in Montana, the five catchment areas are ranked by the Mental Health Field Services Bureau, Department of Institutions, as follows (with a rank of "1" indicating the greatest need):

RANK	CATCHMENT CENTERS
1	Region IV
2	Region V
3	Region III
3	Region II
3	Region I

Procedures Used in Ranking

In order to determine the relative need for purposes of converting to the thirteen mandated services by each of Montana's five centers, a variety of factors was considered. Economic, demographic, social and service aspects were identified; they were individually and collectively evaluated; and the ranking selection was finally arrived at by a combination of objective criteria and subjective analysis.

Rather than submit a detailed listing of socioeconomic indicators with a weighting mechanism attached to make the case for comparative need, a brief description of each catchment area is herewith submitted in order to justify the ranking procedure and outcome. Much of the census data used for determination of need is frequently outdated, arbitrarily selected, and subjectively weighed in any event. Hopefully, this approach to ranking will arrive at similar results in at least as comprehensive a fashion as previous ranking procedures have provided.

RANK #1 REGION IV: SOUTHWEST MONTANA MENTAL HEALTH CENTER & ALCOHOLISM REHABILITATION ASSOCIATION

Administrative Office: 801 North Last Chance Gulch
Helena, Montana 59601

The region of Southwest Montana was the last region founded in the State in July 1975, although the program actually started operation October 1, 1974. This Center is currently budgeted from the State General Fund in the amount of $174,430, the least amount received by any Center. The Center ranks fourth in the amount of Federal monies received. This financial condition has resulted in fewer FTE's than in other CMHC's. Eight of the twelve counties in the catchment area are presently participating in the mental health program (68% of total catchment area), although persons from each non-participating county have utilized some of the services of satellite offices near them. The Aftercare Program also extends itself into non-participating counties, which amounts to a considerable service in that more discharged patients, by far, from Warm Springs State Hospital (WSSH) are released to Region IV than any other Region in the State. Rapid de-institutionalization has impacted Region IV in transitional services more severely than any other because the State Hospital, along with four other major institutions, is found in this catchment area. While services to children have always been a part of the Center's program, there has not been a systematic program in the Region. A formalized children's program is planned and vitally necessary in view of the needs present.

The 1970 census reports the largest total population found in any catchment area of the State to be that in Region IV: 178,200. However, current Chamber of Commerce figures place the population figure in excess of 200,000. For this reason it is also found that in raw numbers the Region has the largest number of children under age 5, ages 5-17, and the largest number of people 65 and over. It has the highest number of marriages and also the highest number of dissolutions due to death and divorce. Additionally, this Region contains the largest number of retired workers, disabled workers, and OASDI beneficiaries. So far as problem areas are concerned that further address themselves to indices of mental health, Region IV maintains the first position statistically in infant mortality, number of abused children, abortions, and total crime rate. Considering the sheer weight of problem areas when coupled with limited professionals and other resources, e.g. the least number of private practitioners per capita and the lack of reservation facilities to assist in serving its off reservation. Indian population in three of the States major "urban" localities, it is apparent that by any definition of need or resource indicators, Region IV is found most in need in terms of conversion assistance.

RANK #2 REGION V: WESTERN MONTANA REGIONAL MENTAL HEALTH CENTER

Administrative Office: Fort Missoula
Missoula, Montana 59801

Region V CMHC includes seven counties, only one of which is a non-participating county. The Western Montana Mental Health Center opened July 1, 1971 and is presently budgeted for $202,193 for the current year. The Centers' total budget for FY '78 is approximately $800,000, assuring its continuance as the least funded or smallest center in Montana. The Center serves the second largest population of the five catchment areas, 169,300 (1970 census). On most of the usual socioeconimic indices utilized in ranking procedures, Region V will rank second overall. Although in some social and health indicators, such as medical assistance recipients, males in low occupation status, and families under stress due to recent moves, this Center ranks first. Clearly a condition of need -- coupled with a largely rural population and one major Indian reservation can be made. It is only the necessity of priority ranking according to perceived needs within the definition of conversion grant ranking that places this Region in second ranking order.

RANK #3 REGION III SOUTH CENTRAL MONTANA REGIONAL MENTAL HEALTH CENTER

REGION II NORTHCENTRAL MONTANA COMMUNITY MENTAL HEALTH CENTER

REGION I EASTERN MONTANA MENTAL HEALTH CENTER